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INDEX.

PAGE

Abdominal Cases, Some Acute 379
Abscess, Extra-dural, following Middle Ear Suppuration 5
Academic Costume, The Distinctive Hoods and Gowns of 266
Actinotherapeutics, Two Lectures on, by Mr. Gerald Sichel 336
Address, Change of 20, 30, 51, 153, 200, 220, 243, 274, 308, 320, 346, 372, 401, 425, 442, 472, 492, 501, 524
Alcohol and Children 504
Alopecia, Pathology and Treatment of 50
Anæmic Vomiting 416
Anæsthetic, Chloryl 311
Anatomy and the Dissecting Room: How to begin Work 387
Anthrax, An Interesting Case of 423
Antitoxin in Diphtheria 169
Antiquarian Department in the New Museum ... 156
Appendicitis, Remarkable Vitality in a Case of ... 345
Appointments, Medical School 39, 113, 188, 199, 280, 304, 404, 469
Civil 8, 53, 71, 93, 154, 180, 220, 244, 280, 304, 332, 347, 372, 385, 422, 469, 485, 510
Naval and Military 8, 39, 53, 71, 93, 154, 180, 220, 244, 280, 304, 332, 352, 372, 385, 422, 441, 492, 504, 536
Artificial Feeding of a Premature Infant in the Incubator... 92
Assault of Arms 139
Avenue Theatre and Medical Students 182

Badcock, Mr. J. H., Resignation of 70
Presentation to 135
Beany Scholarship 317
Beddard, Dr. A. P., Anæmic Vomiting 416
Berlin and its Clinics 38
Birkett, Mr. John, Obituary Notice of 302
Births 40, 60, 80, 100, 160, 180, 200, 220, 244, 264, 284, 308, 332, 352, 372, 412, 452, 472, 492, 512, 536
Black, Mr. Kenneth, The Relation of Dental Caries to Disease 172
Blood passing from the Rectum, Some Cases of... 516
Bob Sawyer in 1823 56
Boer War Memorial 30

PAGE

Bonsor, Mr. Cosmo, Speech at the Students' Club Dinner 427
Broncho-Pneumonia... 124
Bryant, Dr. J. H., Some Acute Abdominal Cases 379
Buyers, To Intending 523

Cæsarian Section 110, 288
Cadbury's Christmas Chocolate 531
Caffeine, Preparations of 16
Calendar 20, 40, 60, 80, 100, 160, 252, 284, 308, 432, 451, 472, 492
Cambridge University Pass Lists 20, 56, 91, 121, 138, 154, 191, 214, 243, 261, 273, 288, 442, 475, 524
Regulations for the Examination in Tropical Medicine and Hygiene 157
Cancer, Discussion on 32
in Kafirs, Suggested Cause 131
Cardiac Dilatation, Acute 77
Disorder, The Treatment of ... 505, 526, 532
Caries, Dental, The Relation of, to Disease ... 172
Cats versus Rat-traps 503
Cavillings 488
Centurions' Dinner Club 488
Chapel Choir, Students' 11, 194, 331, 398
Fund 330, 372
Proposed Memorial in the ... 304, 316
List of Names for the 349
Notices 71
Chess Club 160
Children's Christmas Tea Fund 179
Children and Alcohol 504
Chloroform Administration, A New Method of ... 255
Chloryl Anæsthetic 311
Cholangitis 137
Christian, Princess, and the Ladies' Association 229
Christian Union Meetings 70, 398, 442
Christmas, Children's, Tea Fund 179
Concerts in the Wards... ... 13, 14, 15, 16
In Guy's, by a Patient 17
Week—The Niggers 1, 13
In the Wards 513
Chylous Ascitic Fluid, The Examination of ... 464
Claxton, Mr. E. I., M.B., Case of Henoch's Purpura 92
Blue Urine ... 150

CLINICAL LECTURES— PAGE

Dr. Beddard—
Anæmic Vomiting 416
Dr. J. H. Bryant—
Some Acute Abdominal Cases 379
Mr. C. H. Fagge—
Extra-dural Abscess following Middle Ear Suppuration 5
Facial Paralysis complicating Middle Ear Disease 356
Common Forms of Internal Ear Deafness 144
Dr. J. Fawcett—
Acute Hæmorrhagic Pancreatitis ... 84
A Case of Enlarged Liver and Glands, with Purpura and Fatal Hæmatemesis. ? Sarcomatosis 457
Mr. C. H. Golding-Bird—
Gastrostomy in Cancerous Stricture of the Œsophagus 204
The Surgery of Dilated Stomach and Movable Kidney, and their relation to Glénard's Disease 268
Mr. C. Higgens—
Discharge from the Eyes 184
Dr. P. Horrocks—
Two Cases of Cæsarian Section 288
Dr. Lauriston Shaw—
Cerebellar Tumour 436
Mr. F. J. Steward—
Atrophic Rhinitis 64
Acute Intussusception 311
Internal Derangement of the Knee-joint 436
Mr. Charters Symonds—
Nine Cases of Ovariotomy for Torsion of the Pedicle 223
Dr. Frederick Taylor—
Diphtheria 164
Mr. J. H. Targett—
Some Causes of Uterine Hæmorrhage ... 25
Dr. Hale White—
Henoch's Purpura 44
Pneumonia 104
Lobar-Pneumonia and Broncho-Pneumonia 124
A Case of Chronic Jaundice 476
Two Cases of Acute Miliary Tuberculosis 496
Some Cases in which Blood was passed from the Rectum 516

Clinical Lectures, Notice of 7, 28, 50, 69, 89, 109, 420, 439, 462, 481, 501
Dental Lectures, Notice of 12
Clowes, E. F., A Case of Thrombosis of the Pulmonary Artery following Labour ... 401

CLUBS—
Chess 160
Christian Union 70, 442
Debating 69, 71, 234, 485
Hockey 140, 160, 489, 490, 491, 512, 536

CLUBS (*continued*)— PAGE
Junior Guyite 256
Lawn Tennis 199, 243, 261, 264, 281, 308, 352, 432
Rifle 264
Students' 426
Swimming 160, 199, 261, 281, 306
Clubs' Union, Guy's Hospital, and Constituent Institutions 402
Statement of Receipts and Expenditure 230
Coal Tar, A Preparation of 52
Cock, Dr. F. W., An Antiquarian Department for the New Museum 156
The Life-work of an Eighteenth Century Man-midwife 462
Retirement of 202
Coma, Diagnosis and Treatment of ... 214, 235
Combe, Dr. Orloff, Testimonial to 135, 302
Concerts, Christmas, in the Wards 1, 14, 15, 16, 513
Nurses' Choral Society and Students' Glee Club 8, 95, 522
Smoking 123
Conjoint Examining Board in England—
Appointment of Examiners 280
Pass Lists ... 56, 78, 169, 191, 288, 350, 471, 487
Syllabus of Examinations for 1904 52
1905 482
Convalescent Homes, Patients sent to from Guy's Hospital during 1902 and 1903 ... 58
Conversations, Real 198
Cooper, J. Sephton, M.B., The Uses of Electricity and Light in Surgery 367, 405

CRICKET—
Batting and Bowling Averages 252
Cup Tie 351
Fixtures 199, 219, 261, 281
Matches—
v. Addiscombe 283
v. Beddington 220
v. Blackheath 307
v. Bluemantle 241
v. Charing Cross 262
v. Crofton Park 283
v. Gravesend 306
v. Hampstead 262
v. Hos.-Scho. 307
v. London 307, 351
v. London County 219, 281
v. M. C. C. 306
v. New Eltham 308
v. Norbury 241
v. Norbury Park 263
v. Old Colfeians 262, 283
v. Old Olavaians 263
v. Reigate 261
v. R. E. I. C. 220, 307
v. St. Bartholomew's 282
v. St. Mary's 282

CRICKET (*continued*)—
v. St. Thomas's 251
v. Sevenoaks School 264
v. Surrey Club and Ground... 242
v. Thespids 242, 263
v. Wanderers 241
v. Westminster 242
v. Wiseton 332
Past v. Present 282
Cystoscope, The Use of the, in the Diagnosis of Urinary Disease 276

Dance, Residents' Annual 81, 93
Davies-Colley Memorial Book Plate ... 150, 171
Daw, Mr S. W., The Examination of a Chylous Ascitic Fluid 464
Deaths 60, 80, 120, 160, 180, 284, 308, 332, 372, 412, 432, 452, 472, 512
Deafness, Internal Ear, Forms of 144
DEBATING SOCIETY—
Reporting Debates 71
"That Marriage is a Bar to Success" .. 69
Ladies' Night 102
"That in the opinion of this House the Production and Sale of Alcoholic Liquors should be placed under the control of the Government" 485
Dinner 234
Dental Department—
Badcock, Mr. J. H., Resignation of 70
Entrance Scholarships 422
Lectures, Notice of 12
L.D.S. Pass Lists 78, 214
Papers, Rarity of, in the Gazette 494
Surgery, Revised Regulations for the Examination in 138
Syllabus for L.D.S. Examinations 319
Society Meetings 30, 199, 256
Papers read before the Society—
"Anæsthetics used in Dental Practice." By Mr. J. S. Mawer 89
"Evolution in its relation to Odontology." By C. D. Wallis 321
Presidential Address. By Mr. R. Wynne Rouw 469
Dinner 82, 96
Diagnosis, Case for 154
Solution of 200
Case for 273
Solution of 284
A question of 228
Diarrhœa in the Newly-born 275
DINNERS—
Officers' and Servants' 72
Dental Society's 82, 96
The Oxford and Cambridge 475
The Centurions' Club 488
Guy's Hospital Students' Club 426
DINNERS (*continued*)—
Residents' Going Off 420
Guy's Hospital Biennial 294, 316
Junior Guyite Club 256
Dining Room Dialogue 259
Diphtheria, Clinical Lecture on 164
Antitoxin 169
Dressers and the "take-in" week 156
Durham University Pass List ... 191, 244, 430, 471

Eason, Dr. H. L., appointed Dean of the Medical School 44
Eclampsia, Post Partum, A Case of, Recovery ... 274
Eczema, Pathology and Treatment of 110
Electricity and Light, The uses of, in Surgery 367, 405, 469
Endocarditis, Malignant, A Case of, treated with Antistreptococci Serum. Recovery after four months 150
Evolution in its relation to Comparative Odontology 321
Examination Results—
B.S. London 20, 24, 502
Conjoint Board in England—
Final Examination 191, 350, 487
Second 56, 169, 288, 350, 471
First 56, 169, 350, 471
D.P.H. 350
Dental Entrance Scholarship 422
Second Year's Students' Prize .. 422
Diploma of Tropical Medicine and Hygiene, Cambridge 350
D.P.H. Cambridge 191, 442
F.R.C.S. Edin. 154
F.R.C.S. England 24, 524
Hilton Dissection Prize 199
Indian Medical Service 78
Intermediate M.B. London 113, 350
L.D.S. England—
Final Examination 78, 214, 502
First Professional Examination... 214, 502
M.B. Cambridge 20, 56, 91, 138, 154, 214, 243, 261, 273, 288, 524
M.B. Durham 191, 244, 430
M.B. London 243
M.B., B.S. London 502
M.B. Oxford 288, 524
M.Ch. Oxford 288
M.D. Durham 244, 471
M.D. London 20, 332
M.D. Oxford 154, 273
M.R.C.P. London 78
M.S. London 20, 24, 332
Preliminary Scientific, London ... 113, 350
Royal Army Medical Corps 78, 261, 350
Scholarships, Entrance 422
in Dental Mechanics 199
Eyes, Discharge from the 184

PAGE

Eyre, Dr., and the Scottish Life and Fidelity Insurance Company 246, 252
Testimonial to 279, 362, 366

Fable, Another Pointless 258
Fagge, Mr. C. H., Extra-dural Abscess following Middle Ear Suppuration 5
Common Forms of Internal Ear Deafness 144
Facial Paralysis complicating Middle Ear Disease 356
Fawcett, Dr. J., Acute Hæmorrhagic Pancreatitis 84
Feeding, Artificial, of a Premature Infant in the Incubator... 92
Fevers, Instruction in 13
Fibroid, Four Cases of, complicating Pregnancy 57
Field, Dr. G. H., Case of Henoch's Purpura ... 130
Finsen Light in Therapeutics 336
Fire Brigade, Guy's Hospital 246, 310
Extinguisher, The Royal 136
Fœtus, Abnormal Proportions of 194
FOOTBALL—
Association Matches—
v. Charing Cross 139
v. Ewell 490
v. Hastings 511
v. London 99
v. New Beckenham 450
v. Normanhurst Druids 450
v. Old Westminsters... 490
v. St. Bartholomew's 79, 159
v. St. Mary's 120
v. St. Thomas's 99, 140
v. South Eastern College 40
v. Surbiton Hill 511
v. The Casuals 472
v. Westminster School 451
Cup Ties 79, 99, 120, 139, 140
Fixtures 18, 39, 59, 78, 98, 431, 450, 471, 489, 511
Rugby Matches—
v. Catford Bridge 39, 472
v. Dulwich College 450
v. Ealing 472
v. Epsom College 490
v. Harlequins 450
v. Kensington 78
v. Lennox 471, 490
v. London 119
v. Northampton 19
v. Old Merchant Taylors 511
v. Richmond 19, 536
v. Rosslyn Park 59
v. St. Bartholomew's 79
v. Streatham 489
v. University College Hospital 99
Cup Ties 19, 119, 120
Fixtures 18, 39, 59, 78, 79, 98, 431, 450, 489, 511
Formawn 531

PAGE

Fracture, Depressed, Case of. Fractured Base. Recovery. No Sequelæ 195
Depressed, of the Skull, with Laceration of the Cerebral Cortex, A Case of 501
Fractures, The Present System of Treating 72, 112, 136
F.R.C.S. England, Appointments of Examiners 280
Pass List 524
Freshmen, October, To the 373

Galton, The Francis, Research Fellowship ... 466
Gastrostomy in Cancerous Stricture of the Œsophagus 204
Gazette's Special Pathologist, From the 39, 220, 224, 258, 267, 331, 350, 366, 412, 466, 492
General Practitioners, Letters from 171, 193, 210, 257
Glénard's Disease 268
Glee Club, Students' 398
Golding-Bird, Mr. C. H., Gastrostomy in Cancerous Stricture of the Œsophagus 204
The Surgery of Dilated Stomach and Movable Kidney and their relation to Glénard's Disease 268
Gordon, Mr. Robert, Speech at the Students' Club Dinner... 426
Gordon Lectures in Experimental Pathology, Syllabus of 200
Goschen, Viscount, Speech on Prize Day 298
Guardians and Guy's Hospital 41
Guyite, Junior, Club Dinner 256
Guy's Hospital, The Position of, in 1903 21
Biennial Dinner 294, 316
Chess Club 160
Children's Christmas Tea Fund... 179
Christian Union 70, 442
Christmas Week at ... 1, 13, 513
Clubs' Union 230, 402
Debating Society 69, 71, 485
Dental Society 89, 199, 469
Donations to, by Patients ... 58
Fire Brigade 246, 310
And the Guardians 41
Historical Articles, relating to ... 487
Hockey Club 140, 160, 489, 490, 491, 512, 536
Ladies' Association 30, 229
Lawn Tennis 199, 243, 261, 264, 281, 306, 308, 352, 432
Massage Classes 29, 30
Officers and Servants' Dinner ... 72
Patients sent to Convalescent Homes 58
Hospital Reports 91
Rifle Association 264
Swimming Club 160, 199, 261, 281, 306
Gymnasium, Pavy 19, 40

PAGE

Hæmatemesis, Fatal 457
Hæmorrhage from the Rectum, Some Cases of 516
Uterine, Some Causes of 25
Hare and Hounds 100, 140, 420, 451, 536
Heart Disease, On 505, 526, 532
Henoch's Purpura 44, 92, 130
Henson, Dr. W. W., Cancer in Kafirs 131
Hicks, Mr. H. T., A Few Notes on Four Cases of Fibroid Complicating Pregnancy 57
Higgens, Mr. Charles, Discharge from the Eyes 184
Hockey Club, Fixtures 489, 490, 511
v. Trinity (Cambridge) 512
v. Royal Military Academy ... 512
v. Ealing 491
v. Greenwich 536
v. St. Bartholomew's 160
v. St. Thomas's 140
v. Puddleton. By "Ward Clerk" 491
Holman, Dr. C., Knighthood of 265
Honey Poisoning, A Case of 11
Horrocks, Cæsarian Section 110, 288
Hospital Ideals—A Nightmare 196
Residents, Health of 29
Types—The Sister 70
Practice, Days and Hours of Attendance on 397
Humour in the Lecture Room 525

Illustrations—
Portrait of Thomas Guy 515
Malcolm Macpherson 172
George H. Savage, M.D.... ... 232
The Medical School Office 31
Guy's Hospital Cup Teams 50
Alopecia Areata 51
Diagram illustrating Case of Scabies ... 89
Sketches Illustrating Cancer in Kafirs ...131, 132
Davies-Colley, Memorial Book-plate... ... 150
Reflections from the new Operating Theatre 190
A Judge of Live Stock 210
Case of Ringworm of Body, showing double concentric rings 211
Operations of Surgery (two of 'em) 345
Diagrams explanatory of Dr. Bryant's lecture on Some Acute Abdominal Cases 379
To illustrate a "Case of Nodular Leprosy" ... 440
Sketches explanatory of paper on Evolution 322, 323, 324, 325, 326, 327, 328, 329, 330
Diagrams illustrative of Mr. Sichel's lectures on Actinotherapeutics 336, 337, 338, 339, 340, 341, 342, 343
Diagrams explanatory of "A Case of remarkable Vitality"... 346
Diagrams illustrating a Case of Anthrax 423, 424, 425
The Baby Show... 443

Illustrations (*continued*) PAGE
Before the "Incisio" 462
J. H. Bryant, M.D., in a Bunker 483
Depressed Fracture of the Skull 501
Indian Medical Service Pass List 78
In Lighter Vein—
Staff Hunt for Treasure 54
An Evening with the Debating Society ... 114
A Curate is a Man 134
Pot Pourri 152
Gazette Prize Competition 170, 192, 254
Pointless Fables... 213
The Poisoner 232
"Forty Years On" 303
The Confessions of Vereunsaeff, the Physician 348
Extraordinary Council Meeting—Dress Reform 348
Cross Channel Swim 429
On Humour 400
Two Dialogues 441
Monologues—The Boro' Matron 467
Inter-Hospital Cup Winners, 1903 50
Assault-at-Arms 139
Intussusception, Acute 311

Jaundice, Chronic 476
Case of recurrent attacks of, Operation, Removal of Gall-stones, Cholangitis. Recovery 137
Jest, On Some rare forms of, occurring in Lecture rooms 525
Joint, Knee, Internal Derangement of the ... 436
"Judge Not"... 97

Kafirs, Cancer in 131
Kidney Disease, Acute, after Measles 91
Movable, The Surgery of ... 268, 362
Kipling, Rudyard, Prize Competition ... 254, 279
Knee-Joint, Internal Derangement of the ... 436
Kocher's Professor, Practice, Some Notes on ... 9

Ladies' Association, Guy's Hospital 30, 229
Lawn Tennis Cup Ties 264, 308
Fixtures 199, 261, 281, 306
Review of Season, 1904 432
v. Blackheath 352
v. Brixton 308
v. East Sheen 264, 352
v. Harold 243, 308
v. Kent 264
v. St. Thomas 264
v. Sidcup 243
v. Surbiton 243, 264
v. Wanstead 243
Leprosy, Nodular, A Case of 440
L.D.S. Pass Lists 78, 214
Examination, Revised Syllabus for ... 319

PAGE

Letters to My Son 94
Library, The Wills 231, 376, 420
Light and Electricity, the Uses of, in Surgery 367, 405
Liver and Glands, Enlarged, with Purpura and fatal Hæmatemesis, A Case of 457
Liquor Carbonis Detergens 52
Lobar Pneumonia 124
London University, Lectures on Advanced Physiology 12
The Francis Galton Research Fellowship ... 466
Pass Lists 20, 24, 113, 243, 332, 350, 502
Rogers Prize 279
Lushington, Mr. E. H., Death of 453

Macalister, Professor Alex., Some Pioneer Medical Books 444
Macpherson, Malcolm, Obituary of 172
Man Midwife, an Eighteenth Century, The life work of 462
Mann, Mr. Harold, The Treatment of Cardiac Disorder 505, 526, 532
Marriages 20, 40, 80, 100, 140, 180, 200, 220, 264, 284, 332, 412
Martin, Doveton, The late 468
Massage Classes, Syllabus of 29, 30
Measles, Acute Nephritis after 91
Medical Books, Some Pioneer 444
Out-patients, At 189, 253
School, Lectures for Session 1904–1905 386
Service of the Navy 155
Skill, The Press on 97
Students at the Avenue Theatre... ... 182
Memorial, Proposed, in the Chapel ... 304, 316
Metropolitan Asylums Board—Instruction in Fevers 13
Miliary Tuberculosis, Acute 496
Motor Car Experiences 523
Moxon, Dr., the late, Pathological Drawings by 348
Museum, The New, Antiquarian Department of 156, 487
Murchison Scholarship 52

Naval Medical Officers, Grievances of 10, 155
Nephritis, Acute, After Measles 91
Nettle-rash, Treatment of 197
Nightmare, A,—Hospital Ideals 196
Nurses' Choral Society and Students' Glee Club 8, 95, 522
Nursing News 53, 98, 151, 256, 331, 347

Obituary—
John Birkett, F.R.C.S. 302
Leslie Adolphe Fothergill, B.A. 4, 11
Malcolm Macpherson, B.A. 172
Robert Charles Basker Shaw 275
Martin, Doveton Arthur William, M.R.C.S. Eng., L.R.C.P. 468

PAGE

Œsophagus, Gastrostomy in Cancerous Stricture of the 204
Oldman, Dr. C. E., Death of 162
Officers and Servants' Dinner 72
Ophthalmia, Forms and Treatment of 184
Out-patients, With Dr. Shaw at 189, 253
Outlook, The, on Medical Skill 97
Ovariotomy, Nine cases of, for Torsion of the Pedicle 223
Oxford and Cambridge Dinner 475
University Pass Lists 20, 154, 273, 288, 524
Syllabus of Examinations for the Medical and Surgical Degrees 481

Pain, The Physiology of 115
Pakes, Mr. Walter C. C., Presentation to ... 304
Pancreatitis, Acute Hæmorrhagic 84
Papers contributed by Guy's Men to the Medical Press 39, 60, 71, 91, 154, 157, 199, 220, 240, 295, 332, 371, 412, 422, 452, 457, 467, 484, 522
Paraldehyde 17
Paralysis, Facial, complicating Middle Ear Disease 356
Passim 1, 22, 42, 61, 81, 101, 121, 141, 161, 181, 201, 221, 245, 265, 285, 309, 333, 353, 376, 413, 433, 454, 473, 493, 513
Pathologist, Gazette's Special, From the 220, 244, 258, 267, 331, 350, 366, 412, 466, 492
Patients, Donations by, to Guy's Hospital during 1902 and 1903 59
Pavy Gymnasium, Assault-at-Arms 19, 40
Peal, Mr. P. A., *The present system of treating* fractures 72
Pediculi, Treatment 252
Phenacetin 17
Phototheraphy 336, 367, 405, 469
Physical Society—Meetings 53, 90, 136, 372, 457, 524
Discussion on Cancer 32
Papers read before the Society—
The present system of treating fractures. By Mr. P. A. Peall 72
The Relation of Dental Caries to Disease. By Mr. Kenneth Black 172
The Diagnosis and Treatment of Coma. By Mr. N. Ivens Spriggs 214, 235
The uses of Electricity and Light in Surgery. By Mr. J. Sephton Cooper ... 367, 405
Some Pioner Medical Books. By Professor A. Macalister 444
Presidential Address. By Sir Samuel Wilks 30
The Treatment of Cardiac Disorder. By Mr. Harold Mann 505, 526, 532
And Training for General Practice ... 10
Physiology, Advanced, Lectures on 12
Extraordinary replies to questions in 349
Physiological Society Meetings 399, 441, 468
The Physiology of Pain. By Mr. J. L. Rankine 115

PAGE

Piping Times of Peace 503
Pneumonia, Treatment of 104
Lobar 124
Broncho- 124

Radium Emanations in Therapeutics 337
Rankine, Mr. J. L., The Physiology of Pain ... 115
Rat-traps versus Cats 503
Rectum, Blood passed from the, Some Cases of... 516
Renal Disease, Acute, after Measles 91
Residents' Annual Dance 81, 93
Resident, Can a, keep fit 29
"Going Off" Dinner 420

REVIEWS—
Allbutt, Dr. T. Clifford: Notes on the Composition of Scientific Papers 233
Allchin, Dr. W. H.: A Manual of Medicine, vol. v. 97
Battle, W. H., and E. M. Corner: The Surgery of the Diseases of the Appendix Vermiformis and their complications 486
Berry, James: A Manual of Surgical Diagnosis 305
Bland-Sutton, J., F.R.C.S., and A. E. Giles: The Diseases of Women 470
Bosanquet, W. Cecil, M.D., Serums, Vaccines, and Toxines in Treatment and Diagnosis... 451
Bourcourt, Dr. M.: Le Ventre, I. Le Rein... 399
Browne, E. A.: Squint Occurring in Children 399
Calder, A. B. · Questions and Answers on Midwifery for Midwives 429
Coats, Dr. J.: Manual of Pathology 158
Corner, E. M.: Clinical and Pathological Observations on Acute Abdominal Diseases 486
Cunning, J., M.B., B.S.: Aids to Surgery ... 158
Ellison, Mary: A Manual of Massage ... 55
Fisher, J. H.: Ophthalmological Anatomy ... 305
French, H. S.: Laboratory Methods... ... 284
Gadd, H. Whippell: Drugs, Their Production, Preparation and Properties 138
Gould, Dr. G. M.: Biographic Clinics ... 159
Gould, A. Pearce: Elements of Surgical Diagnosis 55
Grimsdale, H. B.: Errors of Refraction and their Correction 365
Guy's Hospital Reports, Vol. LVIII. ... 120
Handley, W. Sampson: On the Origin from Accessory Fallopian Tubes of Cysts of the Broad Ligament situated above the Fallopian Tube 219
Herring, H. T., M.B., B.S.: Sterilization of Urethral Instruments 158
Hillier, A.: The Prevention of Consumption 55
Husbands; Forensic Medicine—Toxicology and Public Health 233
Hutchison, Robert, M.D.: Lectures on Diseases of Children... 470

REVIEWS (*continued*)— PAGE
Ince, Joseph: The Latin Grammar of Pharmacy 53
Jones, H. Lewis, M.A., M.D.: Medical Electricity 530
Kidd, Dr. Walter: The Direction of Hair in Animals and Man 98
Kirkby, William: Practical Prescribing and Dispensing 365
Kocher, Theodore: Les Fractures de l'Humerus et du Femur 365
Lamounier, Dr.: New Methods of Treatment 486
Leftwich, Dr. R. W.: An Index of Symptoms 399
Lewers: Diseases of Women 18
Lindsay, Dr. J. A.: Clinical Lectures on Diseases of the Heart and Lungs 159
Lloyd, F. J.: Diseases of the Appendix Vermiformis, and their Treatment ... 233
Lulham, P. H.: Devices and Desires ... 305
Macleod, J. M. H., M.A., M.D., M.R.C.P.: Practical Handbook of the Pathology of the Skin 18
Martin, Dr. Sidney: A Manual of General Pathology 158
Medical Annual 159
Munro, Thomas P., M.D.: Manual of Medicine 18
Newman, George, M.D., F.R.S., D.P.H.: Bacteriology and the Public Health ... 531
Nursing Guide 151
Orr, John. M.D.: Handbook of Public Health 97
Owen, Edmund: Cleft Palate and Hare-lip 347
Paget, Stephen: The Case against Anti-vivisection 284
What we owe to Experiments on Animals 305
Phillips, C. D. F., M.D.: Pharmacology and Therapeutics 284
Smith, G. Bellingham, and the late Dr. J. W. Washbourn: The Infectivity of Malignant Growths... 219
Steele Perkins, Dr. J.: Lateral Curvature of the Spine 233
Stevens, Dr. T. G.: The fate of the Ovum and Graafian Follicle in Præmenstrual Life 98
Sutherland, W. G., M.B.: Dispensing made Easy 158
Symes, Dr. J. O.: Bacteriology of Every-day Practice 233
Taylor, Dr. Frederick: The Practice of Medicine 429
Thompson, Dr. J. A.: Second Outbreak of Plague at Sydney, New South Wales ... 258
Thomson, Alexis, and Alex. Miles: Manual of Surgery 97
Thorne, Dr. L. Thorne: Nauheim Treatment of Chronic Disease of Heart 158
Thornton, John, M.A.: Elementary Practical Physiology 486

REVIEWS (*continued*)— PAGE

Toldt, Dr. Carl: Atlas of Human Anatomy 55, 158, 347, 452, 530
Treves, Sir F.: Students' Handbook of Surgical Operations 470
Tubby, A. H., and Robert Jones: The Surgery of Paralysis 331
Vincent, Dr. Ralph: The Nutrition of the Infant 159
Walker, Dr. Norman: An Introduction to Dermatology 512
Waller, A. D.: The Signs of Life from their Electrical Aspect 366
Ward, A. H., F.R.C.S.: Clinical Studies in Syphilis 233
Watson, J. K.: A Complete Handbook of Midwifery 365
White, Dr. W. Hale: A Case of Intraocular Lipæmia in which Blood was Examined during Life 219
Wiggens, Dr. Denison: Midwifery for Midwives 138
Wright, A. E., M.D.: Anti-Typhoid Inoculation 487
Wingrave, Wyatt, M.D.: Adenoids 399
Younger, Dr. E. J.: Insanity 233
Rhinitis, Atrophic 64
Rhodesia, A Letter from 421
Richards, Mr. Owen, Berlin and its Clinics ... 38
Rifle Association—Armitage Shoot 264
Ringworm, Pathology and Treatment of... ... 212
Robes, Academic, Distinctive Colours of 266
Rogers Prize 279
Röntgen Ray Therapeutics 336
Roots, Farmer, How he got his second wife ... 363
Royal Army Medical Corps—
Advantages of Examination for the 279
Pass Lists 78, 261, 350
Royal College of Physicians of London—
Murhison Scholarship 52
Pass List 78
Royal College of Surgeons of England—
Appointment of Examiners 280
Notice of Lectures 95
Pass List 71, 78, 154, 214, 524
Revised Regulations for the Examination in Dental Surgery 138
Syllabus of Lectures 71
Rowlands, Mr. R. P., A Case of Depressed Fracture. Fractured Base. Recovery. No Sequelæ 195
Revised Syllabus for the L.D.S. Examination ... 319

Savage, Dr. G. H., Reminiscences as a General Practitioner... 234
Portrait of 234
Scabies, Pathology and Treatment of 89

PAGE

Scholarships—
Beaney 317
Dental Mechanics 199
Entrance 422
Sciences, The, at the Guy's Hospital Medical School 387
Seborrhœa, Pathology and Treatment of... ... 153
Shakesperian Prize Competition 170, 192
Shaw, Dr. Lauriston, A Case of Cerebellar Tumour 248
At Medical Out-patients 189, 253
Instruction in Clinical Medicine 501
Skull, Fractured Base, Recovery 195
Depressed Fracture of the, with Laceration of Cerebral Cortex 501
Sichel, Mr. Gerald, Grievances of Naval Medical Officers 155
Two Lectures on Actinotherapeutics 336
Sister, The, Hospital Types 70
Skin Diseases, Out-patients' Department, Notes from the—
Alopecia 50
Scabies 89
Eczema 110
Psoriasis 133
Seborrhœa 153
Urticaria 197
Ringworm 211
Pediculi 252
Prurigo of Hebra 485
South African War Memorial 30
Splanchnoptosis 268
Sport, *see* "Cricket," "Football," "Hare and Hounds," "Hockey," "Lawn Tennis," and "Swimming."
Spriggs, Dr. E. Ivens, A note on Milky Ascitic Fluids 464
Mr. N. I., The Diagnosis and Treatment of Coma 214, 235
Stearn, Surgeon, F. C., R.N., Funeral of ... 180
Stevenson, Dr., Knighthood of 265
Speech at the Students' Club Dinner 428
Steward, Mr. F. J., Acute Intussusception ... 311
Internal Derangement of the Knee-joint 436
Atrophic Rhinitis 64
Stomach, Dilated, and Movable Kidney, the Surgery of, and their relation to Glénard's Disease 268
Students' Chapel Choir 11, 331, 398
Glee Club 8, 95, 398
And Nurses' Choral Concert ... 8, 95, 522
Club Dinner 426
Student, The Pale Young 18
Surgery Fund 330
Swimming Club, Polo Fixtures ... 199, 261, 281, 306

PAGE

Swan, Mr. R. H. Jocelyn, The Use of the Cystoscope in the Diagnosis of Urinary Disease ... 276
Symonds, Mr. Charters J., Nine Cases of Ovariotomy for Torsion of the Pedicle 223

"Take-in," New Arrangements for ... 354, 398
Targett, Mr. J. H., Some Causes of Uterine Hæmorrhage 25
Taylor, Dr. Frederick, Appointed Lumleian Lecturer 63
Diphtheria, Clinical Lecture 164
Speech on Prize Day ... 301
Thrombosis of the Pulmonary Artery, A Case of, following Labour 406
Tooth, Decayed, Impaction of, in the Trachea ... 484
Travers, Dr. Otho R., On the Physical Society ... 10
Tropical Medicine and Hygiene, Cambridge University, Regulations for the Examination in 157
Tuberculosis, Acute Miliary 496
Tug of War Cup 211
Tumour, Cerebellar, A Case of 248
Diagnosis of 248
Turner, Dr. George, Alcohol and Children ... 504
Mr. Philip, A Case of Depressed Fracture of the Skull with Laceration of the Cortex 501

United Hospitals Hare and Hounds ... 100, 140, 420, 451, 536
University Degrees—Distinctive Colours of Robes and Hoods 266
Urine, Blue 150
Urticaria, Pathology and Treatment of 197
Uterine Hæmorrhage, Some Causes of 25

PAGE

Venner's (T.) Works, 1650 edition of 275
Vitality, Remarkable, In a Case of Appendicitis 345
Vomiting, Anæmic 416

Wallis, Mr. C. D., Evolution in its relation to Comparative Odontology .. 321
Wards, Christmas in the 513
Waylett, William, an Eighteenth Century man-midwife 462
White, Dr. W. Hale, Henoch's Purpura... ... 44
Lobar Pneumonia and Broncho-Pneumonia 104, 124
Chronic Jaundice 476
Acute Miliary Tuberculosis 496
Some Cases in which Blood was passed from the Rectum 516
Wilks, Sir Samuel, Illness of 81
Letter of thanks 193
Presidential Address to the Physical Society 448
Wills Library, Prize Competition 231
List of Periodicals received at the 231
Classification of 376, 420
Worldly Wiseman, Dr., Letters from ... 171, 210, 257

X-ray Therapeutics... 336

Zorab, Mr. A., The Examination of a Chylous scitic Fluid 464

PAGE

Swan, Mr. R. H. Jocelyn, The Use of the Cystoscope in the Diagnosis of Urinary Disease ... 276
Symonds, Mr. Charters J., Nine Cases of Ovariotomy for Torsion of the Pedicle 223

"Take-in," New Arrangements for ... 354, 393
Targett, Mr. J. H., Some Causes of Uterine Hæmorrhage 25
Taylor, Dr. Frederick, Appointed Lumleian Lecturer 63
Diphtheria, Clinical Lecture 104
Speech on Prize Day ... 301
Thrombosis of the Pulmonary Artery, A Case of following Labour 406
Tooth, Decayed, Impaction of, in the Trachea ... 484
Travers, Dr. Otho R., On the Physical Society ... 10
Tropical Medicine and Hygiene, Cambridge University, Regulations for the Examination in 157
Tuberculosis, Acute Miliary 496
Tug of War Cup 211
Tumour, Cerebellar, A Case of 248
Diagnosis of 248
Turner, Dr. George, Alcohol and Children ... 501
Mr. Philip, A Case of Depressed Fracture of the Skull with Laceration of the Cortex 501

United Hospitals Hare and Hounds ... 100, 140, 420, 451, 536
University Degrees—Distinctive Colours of Robes and Hoods 296
Urine, Blue 150
Urticaria, Pathology and Treatment of 197
Uterine Hæmorrhage, Some Causes of 25

PAGE

Venner's (T.) Works, 1650 edition of 27
Vitality, Remarkable, In a Case of Appendicitis 34
Vomiting, Anæmic 41

Wallis, Mr. C. D., Evolution in its relation to Comparative Odontology ... 32
Wards, Christmas in the 51
Waylett, William, an Eighteenth Century man-midwife 48
White, Dr. W. Hale, Henoch's Purpura 44
Lobar Pneumonia and Broncho Pneumonia 101, 19
Chronic Jaundice 47
Acute Miliary Tuberculosis 49
Some Cases in which Blood was passed from the Rectum 51
Wilks, Sir Samuel, Illness of 87
Letter of thanks 19
Presidential Address to the Physical Society 14
Willis Library, Prize Competition 23
List of Periodicals received at the Classification of 376, 42
Worldly Wiseman, Dr., Letters from ... 171, 210, 25

X-ray Therapeutics... 33

Zorab, Mr. A., The Examination of a Chylous 46

GUY'S HOSPITAL GAZETTE.

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CONTENTS.

	PAGE.
Passim	1–4
Obituary	4
Extra-dural Abscess following Middle Ear Suppuration. Clinical lecture by Mr. C. H. Fagge	5–7
Concert of the Nurses' Choral Society and Students' Glee Club	8
Appointments	8
Some Notes on Professor Kocher's Practice ...	9–10
Correspondence...	10–11
Students' Chapel Choir Supper	11
The Dental School of Paris	12
Notices	12–13
Christmas Week	13–17
Christmas in Guy's	18
Sport	18–20
Change of Address	20
Pass List	20

Passim.

CHRISTMAS has passed, and with the ushering-in of the New Year we return to a more decorous *régime*. It has been a happy time and a merry one, but few will be found to regret that law and order are again established, and that outraged routine should have begun to reassert itself with vigour. From Christmas morning to New Year's Eve no hitch of any moment marked the conduct of the revels, and the hearty co-operation that made such a result possible is a matter for congratulation. It is to such times that one will look back in after-life, as ranking amongst one's pleasantest hospital experiences, and whatever there was of hard work in the preparation and execution of the same is amply repaid by the many memories laid by for the future.

NATURALLY, the first and foremost object of our attention must be the Niggers. After weeks of preparation, after long hours of painful drumming in of choruses and equally painful drumming out of excrescences, the grand day arrived, and for six busy hours the tambourines clashed, the drums rattled, and the gentle bones purred an accompaniment to the willing male voice. Everybody did his best; everybody sang his best, wheezed his best, and fooled his best, and it is only just to say that everybody was pleased with the great sum total. From Massa Johnson whose insatiable curiosity led to so many startling revelations of the private life of his underlings, to the least of the troupe whose part was mainly mental, the meed of praise must be extended with ungrudging hand. Niggers at Guy's have been for years a recognised Christmas feature. They have varied, like the quality of the beer in the well known anecdote. But like that same beer they have never been bad. And this year the level reached was high, and everyone is to be congratulated.

AND in thanking the Niggers for their services we must at the same time bestow thanks in a quarter which is most likely to be neglected. To that great band of patient workers. Sisters, Nurses, Dressers and Ward Clerks, whose energies made the wards fairy palaces, whose kindly attentions brought happiness and delight to the many patients, we must say once more, as of old, Well Done! It is easy to work in the full glare of the footlights, where every action every line meets with applause, and the world perhaps looks upon the stage as its own creation and approves in hand claps. But behind, in the gloom of the wings are the workers, whose

labours make the spectacle possible, whose names however are unrecognised in the general bestowal of praise. Thus we would call into public notice the nursing staff and the men who have done so much and so modestly. Let the curtain rise on them, and let them share in the general applause.

FINALLY, but by no means least, must we thank Mr. Barnes, the Resident Engineer and his staff. What other man could have faced the enormous strain that was thrown upon him in one short week? When every sister with one accord turned on all the ordinary and all the extraordinary lights in her ward with the inevitable fusion of the main cut-out, it was a smiling engineer who emerged from a breakdown in the laundry and once more restored light. When every sister wanted one more light than her dearest friend and enemy across the way, it was still a smiling engineer who bowed acquiescence, and when those stupid resident fellows gave their absurd entertainment in the Court Room, it was still an imperturbable engineer who forced himself up in a cramped corner and directed the green arc-lamp on Jerry Bundler's Ghost. Thanks, Mr. Barnes, thanks, we could not have done anything without you.

As was expected, the concerts in the wards gained in excellence owing to the diminution in their number, and those responsible for them were not taxed to such an extent as in previous years. A ward concert is an exceedingly complex affair from every point of view; there are three or four distinct types in the audience, and while the patients are always, and naturally the first to be considered, the performer is, of necessity, slightly biassed by the presence of visitors, nurses, and men. This year the compromises, which are inevitable in these cases, were most happy in their results, and the patients were in each concert presented with a programme which could not fail to please. It would be invidious to single out here any particular concert for special mention, and it would be a poor way of rewarding those, who, while furnishing an excellent concert, were unable to secure well-known "stars." We should, however, like to mention specially the excellent posters of the Job Concert, over which Mr. Sidney Bowle must have spent many weary hours. It was an admirable idea, admirably executed, and the artist is to be heartily congratulated.

IT is always with misgivings that one attempts to reply to criticisms in contemporaries, and when the criticisms appear in such a journal as *Truth*, the misgivings are the more powerful. The Medical Profession as a body owes much to *Truth* for its fearless exposures of the many medical and surgical frauds which have from time to time been foisted on that fool of fools, the British Public, and therefore, while we cannot entirely agree with the Editor in his onslaught upon Guy's, we would yet approach a discussion on the matter in an entirely friendly spirit. Briefly, *Truth* takes exception to the conduct of one of our House-Surgeons in recommending a patient to a convalescent home which *Truth* has demonstrated to be a fraud. To the accuracy of the latter statement we shall take no exception, for Mr. Labouchere is generally perfectly sound in facts. What we do protest against, however, is the publication of a purely private and personal letter from the House-Surgeon to the patient's father, without reference to, or permission from, the writer. When the patient's father told the House-Surgeon that the convalescent home was in process of exposure by the "morning papers," that official made enquiries from our own office and found that no complaints had been made by patients who had been sent there before. He therefore felt himself justified in advising the patient to disregard the criticisms of the halfpenny morning papers. The Editor of *Truth* will agree with us that there is a great difference in value between a statement in his paper and one in the gutter press, and the House-Surgeon was unaware at the time that *Truth* had pilloried this institution. Mistakes of a like nature might be avoided if the Editor of *Truth* saw fit to put Guy's Hospital on the free list of his Journal.

WE understand that negotiations are in full progress between our own Gymnasium Com-

mittee and those of the other leading hospitals for the arrangement of an Inter-Hospital contest in Boxing, Fencing and Gymnastics. The date fixed for the committee meeting of representatives from the different hospitals is January 11th, and it is hoped that the event itself will take place early in February. The proposal at present is that there shall be a competition for a challenge cup, the allocation of which shall be decided by points, with a maximum of four for Boxing, two for Fencing, and one for Gymnastics. The original challenge was sent out by Guy's, and we should have liked to see the struggle take place in our own territory, but the general feeling is not unnaturally in favour of neutral ground, and from the purely sporting point of view this decision was inevitable. The Inter-Hospital Boxing Cup is at present held by University College Hospital, but we hope that shortly it will be transferred to our own smoking room, where, together with the new Challenge Cup, it will be in good company.

WE have received a copy of a paper on the "Dental Requirements of the Army," read before the British Dental Association by Mr. Howe, a dental surgeon who held a combatant post in the late war. Mr. Howe's contribution to Army medical reform is the more valuable in that he has experienced in his own person the vicissitudes of a prolonged campaign, and has been able to judge, from special knowledge, the value of sound teeth to the fighting man. From first to last he pleads for proper supervision of the soldier's teeth. When the recruit ceased to be the agricultural labourer and hailed more extensively from the towns, his general physique and more especially his buccal equipment, deteriorated. Hence, the urgency of dental supervision, at all times great, has now become imperative. The army doctor, like his civilian brother, claims but a rather imperfect knowledge of tooth extraction. Conservation to him is a dead letter. And since the trend of modern dental surgery is almost entirely drill and amalgam work, the sooner the British Tommy has a competent dentist to preserve his teeth in peace and war, the better for the national safety.

How can one adequately describe the fairy bowers into which the wards were transformed by any arrangement of mere words? How can one do justice to the work, to the energy, and taste of the decorations in cold passionless printer's ink? The pen of a Stevenson might perchance portray the pictured beauty of Esther, the owled belfries of Addison, the cobweb traceries of Mary, or the festooned glories of Out-patients. To us it is too hard a task to attempt the description of even such striking tone symphonies as verdant-hued Martha, and scarlet-clad Astley Cooper. Job, in the pride of imperialism, discarding ivy for bunting and draperies, Luke nestling shyly in drooping garlands of evergreen, Charity with her golden-birds, and Naaman with its leafy screen. And the others, all beautiful, all admirable, and all reflecting the pride of the sisters and the men who achieved these triumphs. Is it for us to award the golden apple?

THE hearty congratulations of all are due to the Residents for the excellent entertainment given in the Court Room on Monday and Tuesday last. There is no man more harassed and worried at this time of the year than the unhappy resident, and that he can even find time to rehearse is marvellous enough, but that he should play his part with such entire success leaves the average man as speechless with admiration as a going-off ward-clerk or a coming-on president. What if things were not quite as tragic as one would have liked? If they failed at all it was because of the too strong bond of sympathy existing between actors and audience. If the Sisters and nurses were as pleased as their applause seemed to indicate, then the object of the theatricals was certainly attained.

To the enterprising firm of Mr. Symonds an especial word of praise is due, for in addition to providing their patients in Job Ward with a concert which would have been listened to gladly at any West End concert hall, these gentlemen also gave a most excellent performance of the farce "Borrowed Plumes," which was so successful in Lydia that a repetition was insisted upon in Cornelius and Stephen. The

lion's share in the play fell to the House-Surgeon, Mr. Howard, whose amazing versatility is becoming a bye-word amongst his many friends. His conception of Horatio Tattleton was typically unconventional and won rounds of applause from his delighted audience. Mr. Leeming, as Dick Mizzle, was extremely comic, and gave a most creditable exhibition of character acting, while Messrs. Maher, Mills, and Williams, filled their respective parts most adequately. It was most praiseworthy of these gentlemen to saddle themselves with so harassing a thing as the production of a play, and they well deserved their enthusiastic reception.

AT the going-off dinner on December 25th, Mr. George Evans was elected President of the Residents, and Mr. David Trail Vice-President. There can be no two opinions on the wisdom of the choice made by the residents, and it only remains to congratulate Mr. Edgar Faulks, the going-off president, and Mr. Horace Cutler, his deputy, on the admirable way in which they have filled their posts during the last three very difficult months.

MAY we remind our readers that the Annual Subscription of twelve shillings and sixpence to the Clubs' Union for GAZETTE and Reports is now due, and should be paid as soon as possible to Mr. S. H. Croucher, at the Medical School Office.

OF all the public servants, who at this time of the year are accustomed to receive small tokens of esteem, not the least deserving is the postman. Up to the present, however, this functionary has been left out in the cold so far as the male section of the hospital is concerned. Doubtless it is only necessary for us to draw attention to the subscription sheet for the Postmen's Christmas Box, at present waiting in the Library in a state of pristine whiteness, for this unfortunate oversight to be rectified. The customary subscription is so paltry, that those, whose finances have suffered the most severely during the last fortnight, can nevertheless easily respond to this further demand on their generosity. It would be a great pity were so obviously deserving a charity to fail for want of support.

THE Ninth Annual Dinner of the Guy's Hospital Dental Society is due to take place on Saturday, February 13th, at the Trocadero. It is to be hoped that all present Guy's dental men will be there, and that very many of those now in practice will avail themselves of this opportunity of reunion. Tickets can be obtained from the Society's Honorary Secretary, Mr. C. W. Randall.

THE midnight solemnities round Guy's statue were as dramatic a spectacle as they ever have been. If the Old Year made a somewhat unceremonious exit, owing to certain unruly members shouting down the tolling of the bell, at least the present Year cannot complain of a lack of heartiness in its welcome. The bonfire itself was one of the largest on record, and the enthusiasm rose correspondingly high. The past will join in spirit in the rejoicings of the present, and let us re-echo to both the familiar greeting of "A Happy New Year."

Obituary.

Leslie Adolphe Fothergill,

Born, 3rd April, 1880—Died, December 8th, 1903.

Leslie Adolphe Fothergill, the son of Thomas Rowland and Laura Fothergill, was educated at a private school at Tunbridge Wells until 1894, when he went to the South Eastern College, Ramsgate, for five years. At school he was conspicuous in athletics and was second monitor on leaving. In 1899, he went to Emmanuel College, Cambridge, remaining there for four years, and taking his B.A. degree at the end of his third year. Whilst at the University he made many friends and his interest in athletics was unflagging. When he left Cambridge in 1903 and came to Guy's Hospital, it was with the intention of becoming a medical missionary when qualified. He was well known in the University Camps for Public School Boys, and also took an active part in C.S.S.M. work. During his short time at Guy's Hospital he showed much interest in the Christian Union. His death from typhoid fever on December 8th in John Ward, came as a shock and a surprise to all who knew him, for he appeared strong and robust, and was the last man one would have expected to succumb so suddenly. The funeral took place at Tunbridge Wells on Saturday, December 12th. That so promising a life should be cut off thus early is deeply to be deplored, and all will join in offering their sincerest sympathy to the bereaved family.

Extra-dural Abscess following Middle Ear Suppuration.

CLINICAL LECTURE BY MR. C. H. FAGGE.

December 7th, 1903.

GENTLEMEN,—In accordance with the scheme laid down in my last lecture, when we discussed the common symptoms and diagnosis of intra-cranial lesions following middle ear suppuration, I propose to-day to take the first result of inflammation extending inwards from the temporal bone in its anatomical progress—extra-dural inflammation usually ending in abscess (pachymeningitis externa), and propose, before entering upon a general discussion of this subject, to take a case as our text.

F.F., aged 5, was seen on March 8th, 1902, with pain in the left ear and pyrexia. The membrane of the left ear was found to be normal; two days later this ear discharged pus; on April 4th discharge ceased, and pain, gradually increasing, returned with a swelling behind the ear and frontal and left temporal headache; there was no vomiting. On examination the left ear was found bulged outwards and there was redness and œdema behind the ear, but no fluctuation. Pus was found in the meatus coming from an inferior perforation of the membrane; the pulse was rapid, and the temperature was raised to 101. Patient was admitted, and on operating under an anæsthetic there was a general œdema of the superficial structures and a small quantity of pus under the periosteum; the antrum was soon exposed and this, with some adjacent suppurating mastoid cells, was cleared out. On curetting away the carious bone behind the antrum, a patch of dura mater was found exposed by the inflammatory process, which was covered with granulations lying over the antero-external part of the posterior cranial fossa, under which lay the whole of the vertical part of the lateral sinus; more bone was then removed in order to expose healthy dura mater all around the granulating area, and in doing this the mastoid emissary vein was torn and plugged. The whole wound was then packed and dressed daily. By May 2nd the wound was nearly closed and patient was discharged, the ear being dry and the perforation healed some ten days previously. This is, I think, a typical case of acute uncomplicated extra-dural abscess occurring quite early in acute otitis media.

When we come to study the statistics, we find that extra-dural inflammation is twice as common in the male as in the female sex, and this complication, like all other intra-cranial sequelæ of middle ear suppuration, is curiously more common on the right side than on the left: Jansen's statistics place 47 abscesses on the right side to 32 on the left. With regard to ætiology, we find that the majority of cases occur in the first three decennial periods of life in which they are almost equally distributed. Extra-dural inflammation is almost always due to direct extension of disease in the petrous bone, and, in opposition to what I told you last time about intra-cranial complications, is more common in acute than in chronic cases; we find it in 32·9 per cent. of acute as compared with 15·5 per cent. of 206 chronic cases. On operating, its exposure is usually easy, for commonly the bone is found diseased as far as the dura, or a fistulous track is present leading from the natural cavities in the direction of the middle or posterior fossa, and here diseased perivascular channels are frequently to be seen. Most frequently are extra-dural abscesses to be found in that position where the majority of vessels from the mastoid antrum and its adnexa drain, that is, into the sigmoid fossa of the lateral sinus and in the region of the lateral cerebellar lobe: much rarer is pachymeningitis externa extending upwards through the roof of the tympanum towards the dura mater in the middle fossa. We must always be prepared, however, for the absence of a macroscopic extension of the disease and to find no sinus through the bone indicating that disease has spread to the dura mater. In the extension of inflammation to the posterior fossa, a comparatively rare path is occasionally met with when the pus forces its way through the labryinth or through the aqueductus vestibuli and reaches the bed of the saccus endolymphaticus where it lies buried in the dura mater in the posterior cranial fossa; nor must it be forgotten that extra-dural inflammation may be set up by infective vascular changes in the formation of a lateral sinus thrombosis. In whatever method produced, and especially when occurring in the course of an acute middle ear infection, extra-dural inflammation is usually due to a pneumococcal infection; the stages of this process are, firstly, vascular changes in the outer layer of the dura mater; secondly, formation of granulations, and thirdly, formation of pus; or when the process is peculiarly acute, or the infection virulent, gangrene of the dura mater may result without the appearance of a definite collection of pus.

Pathological evidence of this complication is much more commonly observed on the operating table than in the post-mortem room, but the process seems definitely to be associated with caries of the overlying bone in acute cases, whereas in chronic cases necrosis with the formation of sequestra is more common, and in the chronic cases more or less copious collections of pus are present, and rarely granulations alone. The pus raises up the dura mater uniformly in a circle round the first point of infection which is usually the fistulous track, and it is easy to understand that where, as in the chronic form, the process is slow, necrosis of bone results when we remember that the dura mater here acts as the periosteum; so that extension under the diseased dura mater may take place as far as the coronal or sagittal sutures, or over the occipital bone as far as the torcular. In this way abscesses in the neck or post-pharyngeal space may be set up by pus passing through one of the large vascular foramina, for if the communication with the middle ear or the bony fistulous track becomes blocked with granulations, the natural attachment of dura mater to the bone affords no prevention of pus extension. Let us next consider *the natural results and complications* of this disease. I have tried to show that in the majority of cases there is a direct extension of the carious process from the middle ear inwards to the dura, and so the occasional discharge of the contents of an extra-dural abscess outwards through the antrum, middle ear, and meatus is not to be wondered at, and another way in which a temporary cure by natural processes may result is by the formation of a fistula from inside, usually through one of the sutures or through the foramen which affords a passage to the mastoid emissary vein; this, however, is not a result which can be safely looked for, as here the bone is exceedingly thick and the danger of extension inwards is correspondingly great. When, however, such a fistula does result, its usual position is some three-quarters of an inch above and behind the external auditory meatus in the squamous bone, which is here comparatively thin. As opposed to any effort of the pus to force its way outwards, it more commonly results that the disease extends inwards, and this would be far more common than it even is, were it not for the great resisting power of the dura mater to all inflammatory processes. I recently operated on a case which well exemplifies this point, where at a second operation after a primary antrectomy, a large sequestrum, comprising practically the whole of the petrous portion of the temporal bone, was removed from its bed of granulating dura mater, in which there was reason to suppose that it had lain for about three months, and cases of this sort, showing that the dura mater can act as a barrier and prevent extension inwards even for much longer periods, have been recorded.

Hoffmann found that where the extra-dural abscess was the primary intra-cranial lesion, secondary complications occurred in the following order:—brain abscess, sinus thrombosis, leptomeningitis. This at first sight seems curious, for one would suppose that ulceration of the dura mater with secondary infection of the pia-arachnoid would be the usual sequence of events, but post-mortem evidence has shown that almost at the same time as the pus reaches the dura mater, that membrane with the underlying pia mater and brain cortex are bound together by a plastic inflammation setting up a barrier to deeper meningeal infection, so that the pus seldom discharges itself between the dura and pia, but extends directly inwards into the sub-cortical layers of the brain.

The symptoms of extra-dural infection are often unnoticed, for they are mixed up with the symptoms of middle ear and bone disease. Further, especially in acute cases where post-auricular swelling is marked, this complication is often unsuspected even at the beginning of the operation, and the practical value of remembering this is that one should always be prepared to deal with an extra-dural abscess in any acute case requiring apparently a simple antrectomy. In uncomplicated cases, however, the symptoms would be as follows:—

1. Fever, which, however, is often absent, and when present may only indicate extending bone disease;
2. Pain, commonly confined to the temporal region;
3. Signs of increased pressure and local brain symptoms, unfortunately not always present, and commoner in children than in adults. These are general or one-sided headache, drowsiness, vomiting, slow pulse (even reduced to 50 per minute, Jansen), and occasionally optic neuritis. In the posterior fossa rigidity of the neck has been observed by Jansen, Lane, and Page, and Lane calls attention to the fact that in his cases no arachnitis was present. In the middle fossa crossed paralysis and anæsthesia, and on the left side sensory aphasia are occasionally met with, and nystagmus has also been observed.

External signs are much more reliable, but perhaps even less frequent.

1. Profuse and unusual otorrhœa from the emptying of the abscess;
2. Swelling, in those cases where pus escapes through the bone or a foramen of an emissary vein. Here we should also find pain on pressure, redness, and œdema, with deep-seated pain behind the ear and a fluctuating swelling. By this the muscles of the neck may be involved at their insertion into the mastoid, so that limitation of the movements of the head, especially in the sagittal, but also in the vertical and transverse axes, are to be looked for.

From a consideration of the above it will be clear that *the diagnosis* from the lack of pathognomonic symptoms and signs is always difficult and often impossible, for you will readily realise that any of the above evidences may be due to mischief deeper than the dura mater. Occasionally, however, profuse intermittent discharge may be of help in that it indicates emptying of an intra-cranial abscess when it is associated with cessation of brain symptoms after the discharge of the pus. Sometimes the position of the swelling may be of help, for when due to an extra-dural abscess bursting outwards it is usually situated well behind and above the ear and not immediately over the antrum as is the sub-periostal swelling secondary to acute uncomplicated mastoid disease. Finally, after an operation confined to the antrum, persistence of serious symptoms may suggest extra-dural infection and lead to its appropriate operative treatment.

In considering the *prognosis* we must just bear in mind the possibility, of which I spoke above, of a natural though temporary improvement by the formation of an external fistula; yet this, which can only be extremely rare, scarcely alters the exceedingly grave outlook if the barrier of dura mater is passed, when, without operation, only death can result; on the other hand, so good is the prognosis in uncomplicated cases after operation that in the absence of recorded fatalities or of fatalities in my own experience, I should be inclined to place it at 100 per cent. It is true my own experience has been hitherto small, comprising some 10 acute or chronic uncomplicated cases which have all ended satisfactorily. *Operative treatment* must therefore be undertaken for two reasons, firstly, because of the danger of complications, and secondly, because of the freedom of operation from danger. I do not here propose to take you through the different steps which are usually necessary, but I feel sure that the procedure should always begin with exposure of the mastoid antrum and the adjacent cells, if the latter are found to contain pus or granulations, and from this starting point that tracks of diseased bone should be freely curetted or gouged away until the diseased dura mater is reached; then bone, even if healthy, must be freely removed until a circle of bluish-grey healthy dura mater is exposed all around the diseased area, for which I find Jansen's forceps quite the best instrument. In my experience quite satisfactory results are obtained by packing the resulting cavity and allowing it to granulate up, the complete mastoid operation having first been carried out except in occasional acute cases where the middle ear is little affected.

Before finishing we must spend the few remaining minutes in discussing one or two important points, and the first is, Should the dura mater be always explored in every case when symptoms such as the above come on in the course of acute or chronic suppurative otitis media, arousing suspicions of the presence of an extra-dural abscess? Körner (Die otitischen Erkrankungen des Hirns) records his opinion that he has never seen any unpleasant result follow the free exposure of dura mater either purposeful or by accident, and is therefore inclined to support Lane's view that as a rule when pus or a cholesteatomatous mass is found in the antrum the dura mater should be laid bare, which view was founded on the report of a case in the *Lancet* of 1891, where the author had evacuated an extra-dural collection of pus to the presence of which no sinus from the antrum or middle ear pointed. At the present day aural surgeons would probably agree that when there was any question of extra-dural infection, its free exposure was the wisest course, but on the other hand it is common experience that in many cases it must be unnecessary.

Exuberant granulations on the outer surface of the dura should as a general surgical principle be curetted away, and where the process has been so acute as to end in gangrene, the whole unhealthy area must be freely excised.

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Wednesday, January 4th and 11th, 1.30 p.m., Clinical Surgery, by Mr. Jacobson.

Saturday, January 7th and 14th, 1 p.m., Clinical Medicine, by Dr. G. Newton Pitt.

Monday, January 9th, 1.15 p.m., Lecture by Dr. Horrocks.

Monday, January 16th, 1.15 p.m., Lecture by Mr. Higgens.

Concert of the Nurses' Choral Society & Students' Glee Club.

THE members of the Nurses' Choral Society and Students' Glee Club gave an excellent concert in the Court Room on Tuesday, December 15th, before a large and appreciative audience.

The concert was given under the conductorship of Mr. Henry Taylor, who, when one considers the executive difficulties he has to surmount at a place where everybody has many duties to perform and very little time to spare, is to be greatly congratulated on its general success.

It must be considered very praiseworthy that such a large and effective chorus can be recruited from the ranks of the workers at Guy's; and it would also seem, now that music is so firmly established here, that the combined attractions of the Choral Society and the Chapel Choir should be the means of bringing many lovers of music, both nurses and students, to the hospital in the future.

The most important item of the programme was Macfarren's popular cantata "May Day," which constituted the whole of the second part of the programme.

It is rather to the first part of the programme that these remarks will be confined, for although the cantata is academically good, and for some obscure reason often chosen for similar performances, and although rendered on this occasion with plenty of spirit and animation, and with the utmost regard for its peculiarities and intricacies, yet it remains to the average musical intelligence a tedious affair, presenting very few points of interest in the setting, and practically none at all as far as the libretto is concerned.

The concert opened with an inspiriting chorus, "The Grape-Vine Swing" (Lohr), in which not only could the excellent balance of the choir be at once noticed, but also, in these days of the all-pervading orchestra, when the basses do not attempt to sing against the "accompanying" trombones, and the sopranos only attempt to make themselves heard on the high notes, it is most gratifying to hear each part clearly and distinctly rendered in a way that was convincing that a most excellent entertainment was in store for those fortunate enough to be present.

An ancient madrigal, "Matona, lovely maiden" (1520–1594) (Lassus), was next given with much grace and delicacy, and formed a fitting contrast to the preceding number.

Mr. Faulks, who then followed with a rollicking song entitled, "The little Irish Girl" (Lohr), has improved immensely both in voice and execution, so that he may now be fairly ranked as a baritone of first-rate order.

Nurse Woodward was recalled for her beautiful violin solo "Largo" (Handel), and "Kuywiak" (Weiniawski). The Male Voice Quartette, Messrs. Hammond-Smith, Morris, Felton and Alan Forty, which next followed sang, "My lady is so wondrous fair" (Calkin) and "The Goslings" (Bridge), the latter of which, blending a few of the opening bars of Mendelssohn's Wedding March with the comic element suggested by the title, proved so successful that an encore had to be granted in response to the vociferous applause.

This result was also obtained by the beautiful rendering of the Quintette, "Love is meant to make us glad" (German), by Sister Patience, Sister Lazarus, Messrs. Wyatt, Felton and Forty, the Quintette from Sullivan's "Sorcerer" being given as an encore.

The part songs "Moonlight" (Faning), "You stole my love" (Macfarren), and "The Miller's Wooing" (Faning), were all well given, the last being so good that it must have been the opinion of many present that it could only be a question of time and opportunity that could prevent such a choir performing some much heavier work.

The vocal duet, "The Song of the Birds" (Rubenstein), by Nurse Du Boulay and Sister Lazarus, and the cello duet, "Spring Song" (Trousselle), by Nurse Crampton and Nurse Dawson, were deservedly much applauded, and the appeal for encores would undoubtedly have been granted had time permitted.

Special notice must also be given to the song "Because" (D'Hardelot), by Mr. Wyatt, whose light and tuneful voice is much appreciated, and to the final song and chorus, "Goodnight" (Garrett), in which the solo parts were admirably taken by Sister Lydia and Mr. Hamilton. The latter is possessed of a pleasing baritone voice of fine quality, and it is to be hoped that with a little more experience and training this gentleman will come well to the fore in hospital music.

The falsetto voice of Mr. Hammond-Smith should prove of extreme value to the Society in those always delightful part songs composed for male voices only.

Nurse Taylor proved a most efficient accompanist in the cantata and part songs. Nurse Thorpe accompanied the cello duet, Nurse Nunn the violin solo, and Mr. Larkin the vocal quintettes.

Appointments.

Civil.

FAGGE, C. H., M.S. Lond., F.R.C.S., has been appointed Surgeon in Charge of In-Patients to the Evelina Hospital for Sick Children, Southwark, *vice* F. C. Abbott, M.S., F.R.C.S., resigned.

SIMPSON, GRAHAM S., F.R.C.S., has been appointed House-Surgeon to the Royal Hospital, Sheffield.

Naval and Military.

Dr. WALTER K. WILLS has been appointed Surgeon in the Royal Naval Volunteer Reserve.

Lieutenant H. FULHAM-TURNER, Royal Army Medical Corps (Volunteers), is promoted to be Captain.

Some Notes on Professor Kocher's Practice.

KOCHER is such a familiar name to those of us who have to struggle with the Examiners in Surgery, that perhaps a few notes on what he actually does may be of interest to those who know him only as a name in large print.

The hospital in which he works—the Inselspital—is an instance of a hospital which has sold its site in the centre of a town, in order to expand itself in separate pavilions in the suburbs.

One of these blocks consists of Kocher's wards. It contains a large lecture room, on each side of which is a theatre—one for clean cases, one for septic. The wards are similarly divided, and the whole block stands well away from the others on the slope of a hill in clean country air. The wards are in the charge of four assistants, of whom the senior gets a good deal of operating. They do the entire ward work and write the reports. Students are expected to attend the clinics, and a dozen are admitted daily to see operations. There seems to be no equivalent to the versatile and responsible Guy's dresser. Help at operations and dressings is given by the sisters, and by two men who correspond more or less to Coles, and who are employed indifferently to clean the floor or to give anæsthetics for major operations.

The clinic corresponds more or less to our clinical lectures. Some half-dozen patients are brought successively in their beds by means of a trolly into the lecture room, where they form the material for a lecture of about an hour and a half. The lectures are very good and popular. One or two students are called down to examine the cases and answer questions At the close, the names of those who are to see the operations are written up on the board. The students are very diverse, and about half of them are Russian women of varying ages—married or single.

These clinics are held four times a week during the session, at 8 a.m. After them there is an interval of about half an hour, and then foreigners and the selected students are admitted to the theatre. The theatre is kept uncomfortably warm and damp by a discharge of steam from a pipe in one corner. Fluids of all kinds are thrown indifferently on the floor, and the assistants wear goloshes and white caps in addition to their overalls.

The patient's skin is shaved the night before, cleaned with soap, ether and alcohol, and covered with a clean pad. *Before the operation the cleaning is repeated and* the area isolated with towels. The assistants' hands are cleaned at great length with soap and warm running water, then with alcohol, then again with warm water. The instruments are steam-sterilised and laid out on a towel. The only antiseptic used for clean cases with a normal skin is the 1 per cent. perchloride in which the silks are boiled. Normal saline is used as a lotion.

Kocher is an advocate of gloves. For all septic cases, rectal cases, etc., rubber gloves are worn—the advantages of this are obvious. But Kocher also wears, and makes his assistants wear, thin cotton gloves during an operation. A good many surgeons follow his practice. The gloves are very porous—semi-transparent in fact—but apparently a certain number of germs can be shown to be sweated into them during an operation, and to be caught there. Kocher holds that by wearing these gloves, and frequently changing them, a recognisable quantity of infection is put on one side. For assistants, especially those who desire to test the strength of silks, they are no disadvantage. But when Kocher reaches the important stage of certain operations he takes off his gloves and goes on without them. For ligatures silk only is used in clean cases, and silk of one thickness. One thread is used for small ligatures, four or five together for big ones. It is not quite so handy as single threads, but it is effective, and must simplify preparations considerably.

Anæsthetics consist as a rule of ethyl bromide, followed by ether given lavishly on a mask. It is given by an assistant, a nurse, or a porter, and tends to be insufficient rather than excessive. Kocher's colleagues use chloroform as a routine anæsthetic, which naturally requires more attention.

The operation for goitre, which is very common, is nearly always conducted without any general anæsthetic.

A transverse curved incision is first made across the mass, going barely through the epidermis; then cocaine is injected along this line by means of a syringe with a long needle at right angles to its barrel, and the operation is begun in about a minute. The patient's face is screened off by a cloth on a hoop. There seems to be some pain at two stages—one the skin incision, the other the turning out of the mass. Otherwise it seems to be inconsiderable, and Swiss peasants are a stolid class.

The tumours are often very large, and Kocher works very carefully and nearly bloodlessly, clipping most of even the smallest vessels before their division. The main vessels are tied at once, the isthmus crushed, tied, and divided, and the patient wheeled to one side as soon as the mass is freed. Kocher then begins another operation, while an assistant ties off the innumerable clips which have accumulated during the operation, and sews up the wound. This takes a considerable time—in one case the removal occupied thirty-five minutes—but the wound was not closed till more than an hour later.

These cases are dressed with a massive dressing, and are drained for twenty-four hours. The stitches come out on the fifth day, and the patient goes out on the eighth.

Kocher's present method of treating simple inguinal hernias differs from his earlier one. The sac is cleared, the tip of it is seized in the end of a pair of long curved forceps and invaginated into itself till it is all inside the internal ring, and projects, outer surface inwards, into the abdominal cavity. The end of the forceps is then pressed forwards against the abdominal wall from within,

and a cut is made down on it through skin. muscle, and peritoneum. The end of the sac is pulled out and secured tightly, without twisting, in the wound, which is closed by a stitch. The forceps are withdrawn. The canal is then narrowed by stitches passed with a curved needle through both its walls from outside. It is not opened. The operation is fairly simple, and involves very little interference, but it does not alter the internal ring in any way.

The wound is covered with a layer of xeroform gauze, and over this is put a sealed dressing. A Japanese fan saves a good deal of time. Neither this nor any other abdominal sections, in fact few clean wounds, have the wool and bandage that is our routine.

Hernias go out of hospital eight days after operation. Living in Berne is cheap. Decent board and lodging, with the social advantages peculiar to a boarding-house, can be obtained for four shillings a day.

OWEN RICHARDS.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Naval Medical Service.

DEAR SIR,—In your last issue Mr. Sichel alluded to some letters I wrote to the *British Medical Journal*. I have since received a large number of communications from Naval Medical Officers of all grades, and enclose one of the most striking, which fully endorses the necessity for further medical reforms,—Yours truly,

J. H. BRYANT.

DEAR SIR,—I am very glad to see, by the last numbers of the *British Medical Journal*, that you are taking up the cudgels on behalf of the Naval Medical Officers.

Our grievances are genuine and many—too many to be detailed in a letter like the present.

The Naval Medical Department to-day requires reorganisation far more than ever did the R.A.M.C.

I have, as you are perhaps aware, a relative undergoing his medical instruction at your hospital, and though I have for years been looking forward to the time when I might welcome him into the Service, it is now with extreme reluctance that I find myself bound to confess that such proceeding on his part would be most unwise whilst the medical department is in its present unsatisfactory condition, and I have had to advise him accordingly.

You will say—"Why then do you remain in a branch of the Service into which you would not advise a friend or relative to enter?" Simply because I cannot afford, for financial reasons, to retire.

I entered the Service like most young men, hoodwinked as to the real conditions of service, and only had my eyes opened to its numerous inconveniences, discomforts, and indignities in after years when the question of retirement opened up the further question of £ s. d. Moreover, I have, year after year, been expecting the long-waited-for improvements, which, as you see, are still not forthcoming.

Evidence of the deplorable condition of our branch of the Service and of the discontent simmering amongst its officers—for every Naval surgeon, be he endowed with but the rudiments of self-respect, is, nay, *must* be, dissatisfied with his lot—is overwhelming; nevertheless, a considerable amount of tact and time will have to be expended in dragging this evidence forward into daylight.

The reasons are many. Medical officers at the top of the tree are so saturated with conservatism that they stand aghast at any suggestions for improvement; *laissez-faire* is their cry to all such.

Medical officers dare not communicate with either the lay or medical press openly, and are chary about sending up letters under a *nom-de-plume*, for the authorship of such letters has on not a few such occasions been ferreted out by the Whitehall "detectives" (!) with the result that the unfortunate victim finds himself bundled off, at a few days' notice, to some unhealthy and remote part of the globe. A vile system of "confidential reports"—in plain words, saying behind the reporter's back what you know to be untrue, and would not dare say to his face—makes Naval medical officers afraid to speak about, let alone write upon, such a subject.

If you were to despatch a letter to every Naval medical officer in the Service, asking him for any suggestions relative to the improvement of his particular branch of the service, I feel confident a large number of the recipients would fail to communicate with you for sheer terror of putting their name to a letter, which, should it fall into the hands of any executive or admiralty official, would entail the most disastrous consequences to themselves.

If you are going to honour us by championing our cause, I shall be very pleased if you will allow me to furnish you, either verbally or by letter, with numerous facts which will convince you of the extreme urgency of a thorough reformation of the now drooping Naval Medical Department, and which will open your eyes to the many slights and indignities which medical officers of the Navy have to put up with.—I am, yours, etc.,

John H. Bryant, Esq., M.D., R. N.
8, Mansfield Street, Portland Place,
London, W.

The Physical Society.

DEAR SIR,—As an old Guy's man and a G.P. of some thirty years' experience, I cannot but feel interested in the letters of Messrs. Collins Lewis and Bell Walker. Mr. Walker should remember that all G.P.'s were once

students and therefore see both sides, whereas the student can know only one.

In the fourth paragraph of his letter he thinks it wise to give "comparatively little attention" to treatment, etc. What does he think patients go to doctors for? If he goes into practice he will find that treatment, diet, etc., are the main points. Then he says he hopes to "find the same diseases outside as inside the hospital." Does he? He will find out his mistake before he has been in a general practice many hours.

Now, Sir, I hope that nothing I may say will be taken as casting any reflection on the past or present Staff of the Medical School, as from both I have always experienced the greatest kindness and courtesy. It is the system which is in fault.

At least five out of six students eventually become G.P.'s, and I will specify four subjects of the greatest importance, the first two of which are very imperfectly taught, and the last two are practically ignored.

i. Prescribing.
ii. Dispensing.
iii. Treating patients (not cases).
iv. How to behave to one's brother practitioners.

I could give plenty of examples, but must not trespass too much on your space.

In conclusion, let me ask any thinking man, how he can expect to be properly trained as a G.P. by men who have never done a year's general practice in their lives.

I trust this will offend no one. It is simply the aspect of the matter seen through (I regret to say) the + glasses of a middle-aged G.P.

I hope, if a discussion as to the efficiency of the present training does ever come on at the Physical Society, that I may be there.—I am, Sir, yours faithfully,

OTHO R. TRAVERS.

Leslie Adolphe Fothergill.

DEAR SIR,—I should like to acknowledge through the medium of your columns the two wreaths so kindly sent from Guy's for my brother's funeral, one "With Sincerest Sympathy from the House-Physicians and Clinicals," and the other "In Loving Remembrance from his Sorrowing Friends at Guy's."

The kindness and sympathy which prompted the sending of these wreaths was much appreciated by us, the members of his family, and we would wish all who shared in them to accept our grateful thanks.—Believe me, yours very truly,

Beech Holm, CLAUD F. FOTHERGILL.
Tunbridge Wells, 16th Dec., 1903.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

A Case of Honey Poisoning.

A LADY came to see me in great distress. It appears that she had been eating some fresh country honey for her tea. At the time she had remarked to her friends (who also partook of the same honey without, however, developing any unpleasant symptoms) that it was hot and stinging to her throat. About a quarter of an hour after this her upper lip began to swell and speedily the whole face became œdematous, especially the forehead, the eyes being half closed. There were also symptoms of some œdema of the larynx, the breathing distressed and somewhat difficult. There was also slight sucking in at the supersternal notch. The patient at the same time complained of feeling faint and unsteady; her pulse, however, remained good. Since seeing this case I have made enquiries, but have been able to learn very little on the subject. The condition looked like one of "confluent urticaria." I have found since two or three people who can never eat honey, as it always gives them a sensation of suffocation.

The treatment would seem to be largely expectant, a quickly acting purge had better be given, and, if necessary, the laryngeal symptoms treated as one would any other case of œdematous laryngitis.

I shall be interested to hear from any readers who have come across similar cases the actual nature of the poison, and if the symptoms ever become really dangerous.

H.

Students' Chapel Choir Supper.

THE members of the Chapel Choir had an excellent evening's entertainment on Friday, December 18th, in the Court Room. The President, Dr. Fawcett, occupied the chair, Mr. Cosmo Bonsor being the guest of the evening. Over thirty members, including many of the staff, sat down to an excellent dinner provided by Mr. Wade.

Sir Cooper Perry, who had spent the day travelling from Ireland, felt unable to attend, and wished the meeting every success. The proceedings were quite informal, the few speeches which were delivered being made towards the close of the evening under the influence of good fellowship and in a spirit of reminiscence and sometimes incoherency.

A large variety of vocal and other items was given during the evening, and the programme could doubtless have been prolonged far into the night had it not been for fear of the police.

The departure of Mr. Cosmo Bonsor, who added in many ways to the success of this unique assembly, was the sign for the breaking up of a most enjoyable evening.

The Dental School of Paris.

A MEMBER of the Dental Staff sends us the following extracts from a letter he has recently received from the Guy's dental scholar, who is spending the Winter Session at the Dental School of Paris:—

"The school is situated near the centre of Paris, but about two miles from most of the general hospitals. The building itself is not very imposing in appearance, but it possesses an operating room with about sixty chairs, and two smaller rooms for seeing out-patients, and for demonstrations. In addition to these there is a large lecture theatre and an operating theatre, as well as a fairly large laboratory, and they are at present building an additional operating room for first and fourth years' students, which should hold forty or fifty chairs.

"The teaching staff is very large—I believe there are about thirty altogether. I have made the acquaintance of a large number of these, especially of M. Godon, who is the Director-General of the school, M. Martinier and M. Delais.

"M. Godon invited me to his house, and treated me with great courtesy in every way. I explained to him fully why I had come and what I wished to do, and he promised me any assistance that I might require.

"M. Delais is the chief of the prosthetic work, and his restorative work is very clever. He gives a lot of his time to some of the general hospitals, and seems to be appreciated there. He showed me a patient at one of these for whom he was making an 'appareil,' and who had the malar bone, as well as the superior maxilla, removed for sarcoma of the antrum of Highmore. I am afraid she will not require his apparatus very long.

"The thing that has struck me very much about the majority of the staff and of the students is their keenness. They are not content with working six days in the week, but do so also on Sunday mornings, when demonstrations of subjects of special interest are given.

"There are, I believe, about 240 students at the school, about one-fourth of whom are foreign students (Spanish, Portuguese, Italian, Russian, Swiss, Greek, etc), and about one-eighth are ladies. They are not all working at the same time, but the ordinary day's work commences at half-past eight and lasts until six or seven o'clock, with an interval from twelve until two o'clock.

"In the morning the student does operative work; in the afternoon the operating room is closed and he does prosthetic work. The schedule of practical work is not very exacting, fewer operations of all kinds being required. In addition to these the student has to attend many clinics—which are usually demonstrations—and which occupy a lot of time. Attendance at the clinics is compulsory, but attendance at the lectures is not so, but carries weight with the Faculty of Medicine at examinations. Nevertheless the lectures are invariably well attended, and the attention of the students is very marked.

"There are no house-surgeons at the Dental school, and no student appointments as at Guy's. The new out-patients—which are very few in number, perhaps ten or twelve a day—are seen by one or frequently two of the visiting staff. All work done has to be authorised and 'signed up' by a member of the staff also—usually by a demonstrator, of which three (one of whom is an American) attend regularly in the mornings.

"Anæsthetics are freely given, both local and general. Of the former cocaine hydrochlorate is the favourite, and of the latter scœmoform and chloroform are much more frequently used than nitrous oxide.

"The museum of the school is very good, and contains a large number of excellent wax models of surgical affections of the head and neck, as well as a fine collection of specimens of purely dental interest."

Clinical Dental Lectures—12 noon.

WINTER SESSION, 1904.

Tuesday, January 5th.—Mr. E. B. Dowsett, "Toothache."

Friday, January 22nd.—Mr. R. Wynne Rouw, "Some Thoughts on the Care of the Teeth in Children."

Thursday, February 4th. - Mr. J. Lewin Payne, "Necrosis of the Jaw."

Tuesday, February 16th.—Mr. J. B. Parfitt, "Models and Model Making."

Saturday, March 5th.—Mr. M. F. Hopson, "Odontomes."

Notices.

UNIVERSITY OF LONDON.

ADVANCED LECTURES IN THE PHYSIOLOGICAL LABORATORY OF THE UNIVERSITY.

The following two Courses of Lectures on Advanced Physiology will be delivered in the Physiological Laboratory at the University during the ensuing Winter Term, commencing on Monday, January 18th, 1904, at 5 p.m.

A. "The Physiology of Immunization." By A. E. Wright, M.D., B.Ch. (Dublin). (Lecturer on Pathology and Bacteriology in St. Mary's Hospital Medical School; late Professor of Pathology, Army Medical School, Netley.) On Mondays, January 18th, 25th, February 1st, 8th, 15th, 22nd, 29th, March 7th, at 5 p.m.

B. "The Functions of the Stomach and Intestines." By J. S. Edkins, M.A., M.B. (Cantab.). (Lecturer on Physiology in St. Bartholomew's Hospital Medical School.) On Thursdays, January 21st, 28th, February 4th, 11th, 18th, 25th, March 3rd, 10th, at 5 p.m.

The Lectures are addressed to advanced students, and are arranged to meet the requirements of candidates for Honours in Physiology at the University.

Any member of a London School of Medicine, whether an undergraduate of this University or not, is entitled to a card of admission on application to the Academic Registrar.

Candidates for the B.Sc. Honours Examination may name, for part of their Practical Examination, any two subjects from the published list of Advanced University Lectures of the year previous to such examination.

Cards of admission may be obtained on application to the undersigned.

P. J. HARTOG, Academic Registrar.

METROPOLITAN ASYLUMS BOARD.

INSTRUCTION IN FEVERS, COMMENCING JANUARY, 1904.

A Course of Instruction (three months) in the Diagnosis and Treatment of Fevers will be held at each of the undermentioned hospitals on Tuesdays and Fridays (except at the Eastern, North-Eastern, Grove, and Brook Hospitals) at the times stated below.

EASTERN HOSPITAL, The Grove, Homerton, N.E., at 1.30 p.m. E. W. Goodall, M.D., Medical Superintendent. (N.B.—The Class at this hospital will be held on Mondays and Thursdays, beginning 7th January.)

NORTH-EASTERN HOSPITAL, St. Ann's Road, Tottenham, N., at 2.15 p.m. H. E. Cuff, M.D., Medical Superintendent. (N.B.—The Class at this hospital will be held on Mondays and Thursdays, beginning 11th January.)

NORTH-WESTERN HOSPITAL, Lawn Road, Hampstead, N.W., at 2 p.m., beginning 8th January. W. Gayton, M.D., Medical Superintendent.

WESTERN HOSPITAL, Seagrove Road, Fulham, S.W., at 2 p.m., beginning 12th January. R. M. Bruce, M.R.C.S., Medical Superintendent.

SOUTH-WESTERN HOSPITAL, Landor Road, Stockwell, S.W., at 2 p.m., beginning 5th January. F. Foord Caiger, M.D., Medical Superintendent.

FOUNTAIN HOSPITAL, Tooting Grove, Tooting Graveney, S.W. (N.B.—No Class will be held at this hospital.)

GROVE HOSPITAL, Tooting Grove, Tooting Graveney, S.W., at 2.15 p.m. J. E. Beggs, M.D., Medical Superintendent. (N.B.—The Class at this hospital will be held on Mondays and Thursdays, beginning 14th January.)

SOUTH-EASTERN HOSPITAL, Avonley Road, New Cross, S.E. (N.B.—No Class will be held at this hospital.)

PARK HOSPITAL, Hither Green, S.E., at 2.30 p.m., beginning 5th January. R. A. Birdwood, M.D., Medical Superintendent.

BROOK HOSPITAL, Shooters Hill, Woolwich, at 2.30 p.m. J. McCombie, M.D., Medical Superintendent. (N.B.—The Class at this hospital will be held on Mondays and Thursdays, beginning 4th January.)

The next Course will commence in May, 1904.

Christmas Week.

The Niggers.

THE Niggers this year were well up to the average. That was the unanimous opinion expressed on all sides. From the artistic point of view, perhaps, the level was a little higher than normal, since many of the items showed distinct signs of careful coaching in four-part singing. The melodrama—written, produced, stage-managed, and generally pushed along by the inimitable J. E. Collins—was admirably played and admirably received. The sublime fooling of the individual actors was always funny, and always in good taste, a combination of circumstances usually conspicuous by its absence in productions of this kind. Mr. Edridge and Mr. Sheaf, as the "Of course we can, Brothers," were an excellent pair of low comedians, while Mr. J. E. Collins as "Himself" was equally successful. Special mention must be made of Mr. Hughes as the Lovely Maidüen, with the perpetually assassinated baby.

The troupe in general was good, and snappy with the choruses. The wheezes of the corner men bore in most cases the unmistakable marks of antiquity, but were none the worse for familiarity. In fact, their very familiarity rendered their recognition easy. A special feature of the show was Mr. Jackson's "Derby Day," an original song in quick time, with a rousing chorus, written and composed by Dr. Dudley Greenfield. In Mr. Jackson's hands it received the cordial reception that it merited, and one was sorry that it did not figure more frequently on the programmes. Mr. Parker developed spontaneously a capacity for singing Civil War melodies, and was very happy in his "Polly Wolly Doodle" song, but it is hard to individualise.

All the recognised warblers of the hospital were in the troupe, from baritone Faulks to tenor Wyatt, and all sang up to their best reputations. As to the costumes, there was a pleasing variety of colours throughout, and considerable ingenuity was displayed in the disguises. It is a matter for regret that there is a growing tendency to appear in white. The name Nigger does not put out entirely the white skin, but it would be as well if everyone, without exception, kept to the old tradition and blacked his face.

Messrs. Ash & Co., as is their annual wont, kindly provided every patient and visitor with a programme, the covers of which showed clever prehistoric surgical peeps as conceived by that facile artist, Mr. Gerald Sichel.

MENDAX.

Out-Patients on Christmas Day.

Always a fertile source of entertainment to the Boro' youth, Out-Patients becomes to them a veritable fairy-land on Christmas Day, and this year, for the seventh time in succession, a crowd thronged the iron gates long before the time for admission. Partly by strategy, partly by ticket, 587 of these got in, but once inside no distinction between invited and uninvited guests was possible. With one accord and with one alacrity they dispatched the fare provided, to the equal satisfaction of themselves and the onlookers, and with satisfaction borne of a drum-tight Little Mary, discussed the dessert, pulled the crackers, and awaited the arrival of the Nigger troupe with an ever-changing and deafening ring of popular melody. To the sound of their famous band, and exceeding delight of the spectators, the troupe marched slowly round, awing the more timid by the majestic appearance of the leader and the cut-throat villain at the rear, and stimulating the bolder spirits to assail with ill-directed missiles made from the hidden remains of the feast.

After a short impromptu chorus by the audience, thrilling scenes were enacted in a cinematograph show, but the culmination of enthusiasm was only reached when two magnificent Christmas trees were uncovered, piled up round and about with presents for everyone as they filed past, and as they left the hall a bag of eatables was given to each child to take home.

Among many others, who by gifts contributed to the success of this occasion, were Mrs. Landon, Mrs. Manning, Mrs. Carpmael, Mrs. Hucklesby, Mrs. Lane (clothes); Mrs. Stearns, Mrs. Sicklemore, Mrs. Cruickshank, Mrs. Morrah, Miss Wickham, Mr. L. U. Ransford (dolls); the Editor of *Home Chat* (toys); Mr. Lafone (tea); Mr. Hambro' (trees); Mr. Walter Palmer (biscuits); Mr. Elmer Southwell (sweets).

Subscriptions were collected from the Visiting Staff, the Nursing Staff, the Students, the Hospital Workmen, the Institute, and many others.

Lazarus Concert.

Five p.m. on Monday, December 28th, found this ward well filled with visitors, yet more continued arriving. An excellent concert, well arranged, and in a prettily decorated ward, was the verdict of all those who were present, the strength of the local talent being especially noticeable. The programme opened with a pianola selection, that instrument having relieved many pianists of the thankless task of "playing the audience into attention." Mr. H. D. Wyatt then gave us "So fare thee well," and later on took part with Sisters Patience and Lazarus, Messrs. Faulks and Felton, in two capital quintettes, the title of the first, "She will tend him," being particularly appropriate, while its rendering quite justified the encore, unanimously demanded and kindly given. Miss Collet sang four songs with a soprano voice under good control. Messrs. Hammond-Smith, Reeve, Felton and Forty make an excellent quartette, and had chosen their songs peculiarly well. Miss MacVicar has a well-toned violin, and played it very well in both halves of the programme. Another soprano, Miss Elsie Bridgman, sang "Love the Pedlar" in excellent style, and Miss Frances Sykes was encored for her capital recitation. Mr. Lindsey Squire's songs, "Oh! How I Love Thee" and "Lilies," met with a very good reception, while Mr. Ray Edridge's "That Happy Land," like good wine, "needs no bush." Mr. W. Savage Cooper gave us several inimitable comic songs, of which the one with a musical obligato, consisting of a vocal imitation of the trombone, was the best. Mr. Longson's cello is always well worth hearing, and all the artistes are to be sincerely thanked for the pleasant evening's entertainment, the management of which reflected great credit on those responsible.

The Residents' Theatricals.

The Residents' Theatricals were performed in the Court Room of the Hospital for the first time on Monday, December 28th, and repeated on the following evening. Although on the first night the nursing staff was so largely represented that only a few chance-comers, more fortunate or more persistent than the rest, gained a foothold, at the second performance seats, or parts of seats, were found for all, and what must have proved a real disappointment was prevented.

As last year, the programme was in three parts, beginning with Dr. Stanley Hodgson's dramatic incident in one act, entitled "The Other Girl," and followed in turn by "The Ghost of Jerry Bundler," and the farce "My Turn Next." In the intervals between these pieces, intervals which were wonderfully short, the orchestra, under the direction of Mr. Middlemarsh Longson, played several selections, and there were songs by Messrs. Felton, Bowle and Wyatt.

The first item on the programme was by far the most ambitious—ambitious because it demanded the serious attention of a Christmas audience, and therefore its complete and emphatic success was the more remarkable. The acting throughout was admirable, both in the ease and humour of the earlier part and the sudden thrill of its tragic close. Although in the very last line of the piece "Jack Warwick" hears of the death of the girl to whom he is on the point of becoming engaged, the play does not end until his complete and utter realisation of the news. In this Mr. Woodward was entirely successful, and he was ably seconded by Mr. Edridge as Ralph Gibbons. Mr. Reeve's impersonation of George (Warwick's servant) was excellent, and made us wish that this gentleman could have had a more substantial part.

In the "Ghost of Jerry Bundler" which followed, the same actors took the largest share and had the most difficult task. Mr. Woodward was excellent as Hirst, the practical joker who plays his last joke, while Mr. Edridge had perhaps the hardest task of all, that of charging the atmosphere and "making the funk." He did it so well that the alarm of the audience (everybody shivered, some gasped, and there were at least two shrieks, one louder than the other) was not entirely due

to the extreme violence of Mr. Faulks' revolver. Mr. Blake Odgers, admirably made up, was very good as the waiter George. Messrs. Robertson and Parker as "Malcolm" and "Penfold" were admirable. All smoked hard, Mr. Jackson, an excellent "Somers," perhaps hardest of all.

The entertainment was concluded with the farce, "My Turn Next." Mr. Woodward kept the audience convulsed with laughter as Taraxicum Twitters, and he was supported by a most talented company. Mr. Edridge was extremely clever as Tim Bolus, in love (and no wonder) with Peggy the maid (Mr. C. H. Robertson). That he should have failed over so simple a matter as emptying a mug of beer at a gulp may be taken as showing the urgent necessity of careful and frequent rehearsals. As Lydia and Cecily, Twitter's, virtuous but maligned wife and sister-in-law, Mr. Jackson and Mr. Evans acted with just the right amount of restraint and with infinite humour. Mr. Evans was eminently lady-like; Mr. Jackson's charming figure, and no less charming smile, won all hearts, but for ourselves, for sheer good looks we preferred Peggy the maid. All were charming and none vulgar;—as our Peggy herself naïvely admitted, "She could not stoop to anything low." Mr. David Trail, as "Tom Trap," was the Commercial Traveller to the life; while Mr. Morgan Rees, with a padded front, played the short part of "Farmer Wheatear" most convincingly.

The thanks of all who witnessed the performance are due to the residents, and especially to Dr. Hodgson, Mr. Woodward and Mr. Edridge, for an entertainment which can never have been surpassed in the hospital, while Mr. Blake Odgers and Mr. C. H. Robertson the hard-working property managers, deserve the highest praise from both actors and audience.

Dorcas Concert.

A great feature of the Dorcas Concert, held on December 29th, was that the patients had all the best places, and were not crowded out by the visitors. For this and the other excellences of the arrangements we have to thank Sister Dorcas and Mr. Parker. Nobody is likely to forget the thanks due to the performers. By an unfortunate illness, we were deprived of the services of Miss Trahair, but that lady's sister made up for her absence by her untiring zeal in playing so many accompaniments. The other performers were Miss Parker, the Misses Harrison, Miss Shee, Mr. Faulks, Mr. Black, Mr. Hammond-Smith, Mr. Reeve, Mr. Felton, Mr. Alan Forty, Mr. Palmer, and Mr. Harrison, who gave a most amusing thought-reading performance under the name of "Professor Schneezunkoff." The Misses Harrison received a great reception as "Three Little Maids," from the "Mikado," in costume, and well deserved their encore.

Job Concert.

Not the least enjoyable of the many concerts which have been given in the hospital was the one held in Job Ward last Tuesday afternoon. Messrs. Howard and Wyatt are deserving of the utmost praise for their efforts, and a highly successful entertainment was the result. Songs, recitations, dances and sketches were the order of the evening, and followed each other in quick succession. Among those who kindly gave their services, Mr. Robert Evett gained the most applause for the charming rendering of his three songs, which included "A Song of Araby," and also the old Savoy favourite from "The Gondoliers"—"Take a pair of Sparkling Eyes." Miss Louie Pounds recited very prettily, and she received a well-deserved encore. Mr. Farren Soutar, a son of Miss Nellie Farren of Gaiety fame, sang an amusing little song entitled "That's all," and as an encore told his audience an anecdote of Mr. Beerbohm Tree, in which he gave a capital imitation of that well-known actor-manager. Miss Daisy McGeoch sang "My Sal" very effectively; other songs were given by Miss Bush, Mr. Felton, and a duet by Messrs. Bowle and Wyatt. Mr. Edridge, by special request, recited one of Anstey's pieces, entitled "Hyde Park," and later he caused much merriment by his comic song, "The Happy Land." Miss Daisy McGeoch and Mr. Litchfield gave a short dramatic sketch, which was very well received. Messrs. Turner, Chaplin, Stock and Collins, sang two quartettes during the afternoon, and mention must also be made of the dancing of Miss Trixy McGeoch. Miss Fergusson gave a piano solo, the grand piano having been kindly lent by Messrs. Erard.

A most enthusiastic audience of over three hundred filled the ward from end to end, and showed the utmost delight at the entertainment, which lasted for over two hours. A contingent of patients from Lydia Ward were present, the children, prettily dressed for the occasion, being especially pleased. An entertainment such as this not only speaks volumes for the organisers, but the novel and artistic decoration and arrangement of the ward were not effected without considerable care and thought on the part of all concerned; and Sisters Job and Lydia, the nurses and the firms of Messrs. Symonds and Steward are to be heartily congratulated.

Luke Concert.

There was no lack of enthusiasm on the part of the patients and visitors at Luke Ward on Tuesday, December 29th, on which evening the annual concert was held. The ward was, as usual, very tastefully decorated and a very good programme had been arranged.

Miss Phyllis Carr began the proceedings with a cleverly executed violin solo, and Mr. George Tate sang "The Yeoman of England," and, later in the evening, "The Tinker's Song." "The Three Little Maids," from the "Mikado," was very cleverly acted and sung by Mrs. Weir Rickett, Miss Everell Spain and Miss Edith Waller in costume, and was naturally very much appreciated. Mr. Ray Edridge evoked roars of laughter with his song "The Happy Land," and Mr. R. Constantine also kept the audience in a very good humour with two comic songs.

Amongst the other vocalists were Miss Nita Kendall, who sang her two songs, "Killarney" and "Kathleen Mavourneen" very prettily, Miss E. Waller who gave a

coon song and dance, and Mrs. Weir Rickett, who sang a ballad from "Patience." Miss Everell Spain sang a dainty trifle entitled "A lesson with the fan," and with Mr. Willie Spain took part in a clever little duet, "Quarrelling," which received a well merited encore.

Songs were also given by Miss M. Norris Adams, Miss Jones, Mr. Gordon Wake, and Mr. E. A. Streatfield. Miss James recited "The Rehearsal," and Mr. J. K. Boddy was very humorous in a recitation entitled "My first and last appearance."

Special mention must be made of The Guildhall Glee Singers, who were accorded an enthusiastic ovation for their charmingly-rendered quartettes, each of which was most deservedly encored, their performance being a particularly good one. Messrs. R. B. and L. U. Ransford took part in a whistling duet, and the last item on the programme was a song from the "Gondoliers," sung by Mr. G. Weir Rickett.

The concert, which lasted more than three hours, terminated with cheers from the patients for Sister Luke and the nurses. Altogether a delightful evening was spent, and the entertainment certainly compared very favourably with the many successful concerts of previous years.

Guy's Hospital Nurses' Entertainment.

On Wednesday last, our reporter was refused admission to the above entertainment on the plea that he was of the wrong sex. He managed to secure a programme, appended hereto, and asserts that he saw large chunks of the performance through a hole in the window blind. Wild horses will not tear from him what he saw. He only giggles when asked, and seems to have been quite struck by Aunt Minerva.

PROGRAMME.

PART I.—Pianoforte Duet, Nurses Hucklesby and Withington; Play (in one act), "Aunt Minerva"; Song, "Only a Dream," Nurse Dickinson; Recitation, Nurse Wise; Trio (Violin, Cello and Piano), Nurses Dawson, Crampton and Woodward: Song, "Tatters," Nurse Densham; Vocal Trio, "Distant Bells," Nurses Foster, Dickinson and Nawn. PART II.—Quartette (Violin, Cellos, and Piano), Nurses Du Boulay, Thorpe, Dawson and Crampton; Recitation, Nurse Wise; Song, Nurse Humphrey; Violin Solo, Nurse Woodward; Duologue—Betsey Prig and Sarey Gamp, "How they went sick nursing and quarrelled"; Vocal Duet, Nurses Du Boulay and Humphrey; Pianoforte Solo, Nurse Taylor; Song, Nurse Seather, Dance, Nurses Danson, Mott, Scott and Wrenford; Glee, "Snow." Auld Lang Syne.

Astley Cooper.

When Astley Cooper determines to give a concert, right royal is the result, and the entertainment on December 31st, was no exception to this rule. Everything went with a swing from start to finish, and, if time had allowed, everybody would have been encored: everybody was pleased everybody applauded—a fractured base was seen to raise his head and laugh, while the Pott'ses clapped their splints together and roared. Where all were so good, it is difficult to know which to mention first, but Mr. King deserves special mention for his excellent and varied sketches—as a ventriloquist, as a girl, and again as a countryman he delighted the audience. Miss Wrighton accompanied him, and also sang several songs with a charming voice. Mr. Faulks sang "A Border Ballad" with his usual verve and vigour, while Mr. Lindsay Squire was much appreciated in his two well known songs. As a violinist, Mr. Henry Lewis displayed no mean powers of execution, and Mr. Longson played two very good cello solos. Mr. Wyatt sang "God's Eternity" and "Ma blushin' Rosie"; and Mr. Reeve obtained one of the few encores of the evening with 'Ma curly headed baby:" the softness of this singer's high notes is peculiarly charming. Mr. Edridge sang in his own inimitable manner, and told a tale as an encore; as the envious one remarked "that versatile man plays, acts, sings, and writes all about it in the GAZETTE next morning." Miss Frances Sykes is a capital reciter, and charmed us all with her varied repertoire.

The second part was opened by Mr. Ticehurst's able rendering on the pianoforte of "The Musical Box." Miss Elsie Bridgman sang several songs with a very sweet soprano voice, her rendering of "The Birds go North" being so different to that of Miss Wrighton—who sang the same song in the first part—that, though each was faultless, very few in the audience realised that the same song had been sung twice. One of the gems of the evening was "Cassius and Brutus" by Messrs. Edridge and Woodward, who caricatured Mr. Tree and Sir Henry Irving, previous to which Mr. Faulks gave a very good caricature of a scene shifter. Mr. Woodward's "Bridegroom's Speech" and imitation of Mrs. Patrick Campbell were much appreciated, while Mr. B. H. Palmer is to be warmly congratulated on his make-up and spirited rendering of several songs. The National Anthem and Auld Lang Syne brought to a close one of the most successful concerts that even Astley Cooper has ever witnessed.

Notes on Prescribing.

PREPARATIONS OF CAFFEINE.

Caffeine is usually prescribed either as alkaloid or in the form of citrate.

Caffeine is soluble in cold water to the extent of 1 part in 68, therefore the maximum dose (5 grains) may be easily dissolved in an ounce of water.

Caffeine is very soluble in solutions of potassium acetate, sodium benzoate and sodium salicylate, the last being generally used. Thus 30 grains of sodium salicylate and 4 drachms of water will dissolve 1 drachm of caffeine.

Caffeine citrate.—It should be noted that caffeine is a very weak base, so weak, that when the citrate is mixed with water dissociation takes place and the solution acts just as a mixture of caffeine and citric acid. Thus, with sal volatile, neutralisation of the ammonia occurs; with sodium salicylate the citric acid liberates salicylic acid, which, being insoluble, separates in beautifully long crystals, which in private practice may be a source of alarm to the doctor and the patient.

The object of this note is to point out that while sodium salicylate may be used to dissolve large quantities of caffeine, this substance is incompatible with caffeine citrate for the reason stated.

There seems to be no sufficient excuse for the presence of the latter salt in the British Pharmacopœia. It contains about half its weight of caffeine and is no more soluble than that substance.

Phenacetin.—At Guy's this substance is not usually given in mixtures. Experiments were made to try and find a suitable solvent, as it is practically insoluble in water, but in all cases precipitation occurred when these solutions were mixed with water, so the following suspending agents were tried:—

Tragacanth, 2 grains to 1 ounce of mixture.
Compound tragacanth powder, 10 grains to 1 ounce of mixture.
Mucilage of acacia, 2 drachms to 1 ounce of mixture.

After standing a week, it was found that No. 1 was more easily diffused by shaking than the others. This result confirms those obtained previously with a large number of other insoluble substances, such as salol, bismuth, salts, etc., viz.: that the best suspending agent is tragacanth in the proportion of 2 grains to the ounce of mixture; acacia in any form, mucilage, powder or compound tragacanth powder is not so good, as it forms masses at the bottom of the bottle which cannot be shaken up without very great difficulty.

Paraldehyde.—The solubility of this substance in water is 1 in 10 at 15° C., so that 45 minims are soluble in 1 ounce of water.

To avoid a layer of paraldehyde on the surface of a containing mixture with its accompanying danger of an overdose, it seems advisable never to exceed the above proportions in a mixture.

Should some of the substance separate at a summer temperature, resolution may be effected by simply placing the bottle under the *cold* water tap. Oil of pepperment, 1 minim to the ounce, disguises the taste fairly well.

HORACE FINNIMORE, A.I.C.

Christmas in Guy's.

BY A PATIENT.

I NOTICED the other day an article of a painfully familiar type in one of the illustrated magazines in which a number of distinguished persons gave answers to the question, "How I like to spend Christmas." None of these gentlemen hailed from that happy land which Mr. Edridge has described to us, and they knew that their wives could easily purchase copies of the magazine in question. So they all replied that they liked to be surrounded by their wives and children and dear ones and puddings and Christmas-trees and games and other nonsense of the sort. The editor unaccountably forgot to consult me, or he would have had my answer ready made—"In a hospital"—and I would now add in the fulness of knowledge, "and let that hospital be Guys." When I first said this, I spoke in a vein of dyspepsia, nay of misanthropy. I meant "Let me get away from overeating and playing at being merry and trying to talk to those female cousins who are ordinarily several times removed, but draw round the family fire in painful propinquity at the festal season." But now I mean it quite differently; I have seen it and I have promised to describe as best I may the impression it has produced upon me.

The layman, and especially the layman who comes in as a patient, has an entirely false notion as to the attitude in hospital towards sickness and suffering. He regards it with an exaggerated awe almost akin to terror; he could not do anything to help, so he likes to keep away from what is unpleasant to himself. His mind associates sickness only with ghastly sights and sounds—for the most part entirely of its own creation. Partly, no doubt, this is due to unfamiliarity, but much of it is merely selfishness. Towards a patient he would act with sympathy and even consideration, but *in silence;* he would pull a long face, walk on tiptoe, make whispered enquiries of the nurse; but he could not, dare not attempt to enliven, to amuse. The idea of organised entertainments in all the wards strikes him as impossible, even sacrilegious; it is dancing at a funeral, putting a cracker cap on a skeleton. And then he goes and sees it all. He sees everyone—students, nurses, above all, patients—obviously and patently the better for it. He will be surprised and delighted at the quality and variety of accomplishment shown by the students, and think with amazement of the contrast with an Oxford or Cambridge college as he remembers it. It is not merely the fact that medical students are generally older and drawn from more varied avocations than undergraduates that makes them so much better entertainers; it is, I think, largely the underlying seriousness, the sense of something worth doing to be done that animates them. And our spectator, if he be a wise man, will be something more than entertained; he will have been taught a great lesson; he will have learnt another application of that most profound of aphorisms—

Ars est celare artem.

Gentle reader, when next Christmas comes round, I will arise and go to my surgeon and say to him: "Remove that portion of my frame which can be removed with the greatest scientific interest to yourself and the least inconvenience to me, and arrange that I shall be a convalescent in Bright on Christmas Day, and for at least a week afterwards."

Reviews.

The price of books submitted for review should in every case be stated.

Lewis's Diseases of Women. Sixth edition. Pages 533. (H. K. Lewis.) 10s. 6d.

The sixth edition has brought up to date the previous belated description of abdominal hysterectomy, and is well abreast of modern treatment. In the author's delightfully easy style the whole subject is considered from an experienced and commonsense standpoint, and the points emphasised are almost always illustrated by cases. The causes of symptoms are so carefully enumerated, that the imposing lists, if not quite scientifically exact, are at least very useful in examinations. Thus, while in former editions a long and somewhat indiscriminating list of causes of pelvic hæmatocele was given, now the following remark closes the paragraph: — "Probably almost all, if not quite all, cases of pelvic hæmatocele are due to extra-uterine gestation."

The book enjoys a deserved and wide popularity among students and practitioners, and we can recommend the book as up-to-date and practical.

Manual of Medicine. By Thomas Kirkpatrick Munro, M.D. (Baillière, Tindall & Cox, 1903.) Pages 901. Illustrations 38. Price 15s. net.

The author has added to the Manuals on Medicine a well-printed, large typed book, in the belief that "plenty of room exists for such a manual, since some are too small while others are too large." Whether this be so or not is hard to say.

The articles are neither discursive, nor unduly curtailed. The facts are presented in a rather undigested form but they are complete, and, on the whole, accurate and definite. There is, however, throughout such an entire absence of emphasis, that the relative importance of symptoms and signs is barely ever sufficiently defined. It is unnecessary to go into detail, but general clinical types and results are ignored in favour of a dry, serious statement. The book appears to us to be neither the curt manual of the ward clerk, nor the elaborate and extensive system which the examinee has to face. It lacks much of exactness in treatment. As instance, under the treatment of appendicitis (a difficult subject to write on), the author says that wherever signs of abscess appear an incision is required. And one of the most difficult problems in borderland medicine is thus inadequately dealt with.

Practical Handbook of the Pathology of the Skin. By J. M. H. Macleod, M.A., M.D., M.R.C.P. (London: H. K. Lewis.) 15s. net.

This manual is primarily and essentially a laboratory handbook. Its aim is to acquaint the student with the minute anatomy of skin lesions, and at the same time to enable him to acquire his knowledge at first hand. Bacteriology, in so far as the skin is concerned, naturally finds a place in this volume, and on the assumption that the cancer bodies are blastomycetes, an epitome of the recent technique in connection with these bodies is included. A special mention should be made of the illustrations, which are mostly the work of the author. Appreciating exactly what he wishes to depict, he has succeeded in producing extremely clear and lucid pictures of the various microscopic appearances he describes. The book is not mere compilation of work already extant. It bears the unmistakable stamp of original laboratory work and embodies much of what is the author's own thought. Undoubtedly the book is an essential to the student of dermatology.

Poetry.

"THE PALE YOUNG STUDENT."
(With apologies to W. S. Gilbert).

I.

Time was when work and I were unacquainted;
  Time was, I knew not even "Cunningham."
If "Day" for me dealt many joys untainted,
  "Night" brought me one somniferous grand slam.
At Students' Nights and Smokers I attended
  In company with several other "men";
Nor did I care a button how it ended.
  Ah me!
    I was a Pale Young Student then.

II.

Time *now* is innocent of all vacation,
  Life has become one weary "round" for me:
Gold watch and chain move well on respiration
  When hungry "Little Mary" used to be.
And adipose increases—to my sorrow,
  My scanty locks will *not* grow anyhow;
And though I need'nt trouble for the "morrow,"
  I *wish*
    I was a Pale Young Student now.

From the University of Durham College of Medicine Gazette.

Sport.

Football Fixtures.

SATURDAY, JANUARY 2ND.
G.H.R.F.C., I., v. Old Leysians, home.
SATURDAY, JANUARY 9TH.
G.H.R.F.C., I., v. Catford Bridge, home.
II., v. Catford Bridge II., away.
III., v. Ealing "A," away.
G.H.A.F.C., I., v. Old Reptonians, home.
II., v. Cheshunt II., away.
SATURDAY, JANUARY 16TH.
G.H.R.F.C. I., v. Rosslyn Park, away.
II., v. Surbiton "A," home.
III., v. Old Blackheathens, away.
G.H.A.F.C., I., v. Beckenham, home.
II., v. Beckenham II., away.

Rugby Football.

Guy's v. Northampton.

This match was played at Northampton on December 5th. Guy's lost the toss, and play continued fairly evenly for a while, until, owing to the faulty defence of their backs, Saunders by quick following up, got to a high punt and follow up of O'Brien's, and controlling the ball splendidly doubled over the line with our first try. Harrison failed to convert. A fast game now ensued, the Northampton forwards playing a very hard game and more than holding their own, but our defence was splendid. Harrison's fielding and punting being an especial feature. After a smart bit of passing, F. A. Alcock made a characteristic run and scored our second try, but his brother, in spite of a good shot, failed to convert. The interval found us leading by 6 points to nil. On resuming, Mullins, after a strong rush by our forwards, secured a third try, which O'Brien converted. This reverse induced a temporary improvement in our opponents, but the alertness of McEvedy and Harrison again saved the situation for a time, until their right wing scored after some good passing on the part of their backs. This try was not converted. Emboldened by this success, another try was scored against us, which was converted.

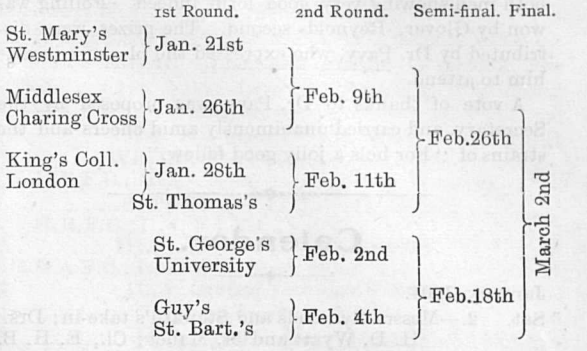
Shortly after, another certain score was brilliantly saved by McEvedy and Harrison, and the game ended in our opponents twenty-five, leaving the Hospital winners by 1 goal, 2 tries to 1 goal, 1 try.

Guy's v. Richmond.

This match, our last of the year, was played at Richmond in pouring rain. Both sides were not quite full strength, McEvedy and Jones being absent from our team. After the kick-off, Richmond at once attacked, but good collaring by Morgan and good kicking by Husbands saved us. The ball coming well away from the scrum reached Harrison, who made a good run but was downed by the Richmond full back before he could pass. The game was chiefly forward after this; the Guy's forwards keeping the ball well at their feet, took it up the ground time after time. In the scrum work, the Richmond pack, being the heavier, managed to get the ball. Half-time arrived without any score. In the second spell the ball was very heavy and greasy so that but little passing could be indulged in. Guy's were penalised upon several occasions for foot up in the scrum and also for off-side. After some good scrum work by our forwards, Cutler got the ball away to Louisson, the latter transferred to O'Brien, who passed to Morgan; after a short run Morgan managed to give O'Brien a beautiful pass back, which was well taken, and so a magnificent try was gained. Harrison failed with the kick. Richmond made several good rushes after this, but every time were defeated by resolute tackling. The game ended with Guy's 3 points, Richmond nil.

REMARKS.—The forwards played a splendid game and to them the chief credit of the victory is due. Saunders. Mullins, Earle and Archer were most conspicuous, though all worked well. Morgan saved many times by his good collaring. Husbands at full back played a good sound game.

Inter-Hospital Rugby Cup Ties.



Pavy Gymnasium.

An Assault-at-Arms was held in the above on December 11th and 12th, to enable representatives to be chosen for Guy's in the Inter-Hospital contests. There was a very large entry indeed, especially for the boxing events, also a very large and enthusiastic audience. Dr. Pavy kindly took the chair, and the judging was carried out by Dr. Allport, Professor Moss and E. P. Minett (Boxing); Sergts. Gilbert and Wheatley (Fencing); and Sergt. Gilbert (Gymnastics). The boxing was an excellent show in every way, especially as most of the men are quite novices, and reflected very great credit on Professor Moss, their instructor. The final winners were (Heavy) Jones; (Middle) Greene; (Light) Gaskins; (Feather) Russell. The middle and light weight bouts were very good indeed, and the judges had great difficulty in making up their minds, in both cases an extra round being ordered, Messrs. Carr and Morgan being the runners up. Other notable bouts were Earle *v.* Jones (Heavy). Greene *v.* Platts, Bookless *v.* Hilyar, Bookless *v.* Carr, Carr *v.* Washer, in the Middle weights; and Marshall *v.* Morgan in the Light weight; these men are all very close, and there is very little to choose between them. The only fault found by the judges was a great tendency to box with open gloves; this is a very serious fault indeed, but with this corrected Guy's boxing men should be a very hot lot for any hospital to tackle.

Two very lively exhibition rounds were boxed afterwards by Professor Moss and E. P. Minett as a finish off.

The Gymnastic Display was excellent and was won by Dyson, who, having won the first prize last year, generously stood aside this, so the prize went to Reader, a very good second indeed, and close up to the winner.

Fencing was unfortunately very wild, and more remarkable for energy than skill, the men making no efforts

whatever, in most cases, to guard themselves. This is a very serious thing and should be changed as soon as possible by Sergt. Gilbert, as at present the fencing is undoubtedly our weakest point, and lays us open to a serious loss of points in the Inter-Hospital contests. The single sticks were won by Oram, Costobadie being second. A notable exception to the above criticisms was the foiling bout between Glover and Reynolds (R. J.), both men showing very good form indeed. Foiling was won by Glover, Reynolds second. The prizes were distributed by Dr. Pavy, who expressed the pleasure it gave him to attend.

A vote of thanks to Dr. Pavy was proposed by the Secretary, and carried unanimously amid cheers and the strains of "For he's a jolly good fellow."

Calendar.

January, 1904.

Sat. 2.—Messrs. Symonds and Steward's take-in; Drs. H. D. Wyatt and M. Maher; Cl., E. H. B. Milsom.

Mon. 4.—Lectures resumed.
February Appointment List opened.
First Part of Conjoint D.P.H. Exam. begins.

Tues. 5.—First Conjoint Exam. begins.

Thur. 7.—Messrs. Lucas and Lane's take-in: Drs. H. P. Costobadie and L. G. Davies; Cl., H. F. B. Waker.
Second Conjoint Exam. begins.

Sat. 9.—February Appointment List closed.

Mon. 11.—Second Part of Conjoint D.P.H. Exam. begins.

Tues. 12.—Final Conjoint Exam. begins.

Thur. 14.—Messrs. Golding-Bird and Dunn's take-in; Drs., P. A. S. Dyson and A. B. Cocker; Cl., A. M. Webber.

Sat. 16.—Physical Society's Meeting at 8 p.m., Clinical Meeting. President, Mr. K. Black.

Change of Address.

Lieutenant-Colonel R. E. R. Morse, R.A.M.C., from York to Leeds.

Major J. V. Salvage, M.D., M.S., R.A.M.C., from Salisbury Plain to Tidworth.

Captain W. G. Beyts, R.A.M.C., from Colchester to the Punjab.

Lieutenant H. V. Bagshawe, R.A.M.C., from Aldershot to Madras.

Dr. Dudley G. Greenfield, from 89, Moreland Road, Croydon, to Wellingborough Road, Rashden, Northampton.

Graham S. Simpson, F.R.C.S., from Guy's Hospital to the Royal Hospital, Sheffield.

Letters for Lieutenant J. H. Horton, I.M.S., should be addressed, M. O., Tribal Horse, Somaliland Field Force, Somaliland.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Pass List.

University of Cambridge, December, 1903.

THIRD EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES.

PART II.—E. Bigg, J. S. Cooper, J. H. Donnell, C. M. Murray, A. Wylie.

PART I.—R. E. French, A. H. Miller, F. W. M. Palmer, C. W. Ponder, C. M. Stevenson, B. H. Stewart, A. Wylie.

SECOND EXAMINATION.

F. A. Barker. G. W. Goodhart.

University of London, 1903.

M.D. EXAMINATION.

T. P. Berry, G. Clarke, D. Forsyth, F. G. Gibson, S. Hodgson, G. E. Richmond, W. M. Robson (qualified for Gold Medal), L. E. Stamm, C. Tessier.

STATE MEDICINE.—H. Nolan (Gold Medal).

M.S. EXAMINATION.

G. E. Manning. R. P. Rowlands.

B.S. EXAMINATION.

FIRST DIVISION.—H. McD. Parrott, C. H. Robertson, Hugh Watts, A. M. Webber, G. T. Wrench.

SECOND DIVISION.—John Evans, T. Holmes, G. Lewin, E. H. B. Milsom, N. I. Spriggs, W. C. Swayne.

University of Oxford, December, 1903.

SECOND EXAMINATION FOR THE DEGREE OF BACHELOR OF MEDICINE.

PATHOLOGY.

A. F. Hertz.

MEDICINE, SURGERY, MIDWIFERY, FORENSIC MEDICINE AND PUBLIC HEALTH.—P. N. Blake Odgers, D. R. Pike.

Marriage.

WYLIE—ELLIS.—On December 9th, at All Souls, Langham Place, W., by the Rev. Arthur McNutt, D. Storer Wylie, M.B., F.R.C.S., second son of A. Howie Wylie, M.D., of Oldham, to Elizabeth, third daughter of Thomas Ellis, of Heathfield, Sussex.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 410.] JANUARY 16, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
The Position of Guy's Hospital in 1903 ...	21–22
Passim	22–24
Pass List	24
Some Causes of Uterine Hæmorrhage. By Mr. J. H. Targett	25–28
Guy's Hospital Massage Classes	29
Can a Resident Keep Fit?	29
Guy's Hospital Dental Society...	30
South African Memorial Account	30
Change of Address	30
Correspondence	30
Physical Society	32–38
Berlin	38–39
Appointments	39
From the Gazette's Special Pathologist ...	39
Sport	39–40

The Position of Guy's Hospital in 1903.

AT this season, when several hospitals are appealing for public support on a scale of great magnitude, it becomes a duty to remind our friends that Guy's is still a suppliant, and that its needs are second to none in urgency. This great charity cannot complain that others should appeal for support on that large and sufficient scale, to which in some quarters, exception seems to be taken, because it was Guy's Hospital that in 1895, first set the example of fearlessly asking for help in measure commensurate with the necessities of the case. Nevertheless, times are bad (although we have never known it to be publicly admitted that any time was good for an appeal), and the fact of a plurality of appeals promulgated simultaneously does not improve their respective prospects of success. And so, the best hope for Guy's at the present juncture lies in the retention of old friends and in their being stimulated to new efforts.

The position is clearly explained by the Treasurer's statement submitted to the last Annual General Court of Governors. From this it appeared that all the wards were now opened, more than six hundred beds being available for patients, and that the cost of maintenance of the whole establishment could not be less than sixty thousand pounds per annum. Towards this the Hospital possessed an income, more or less assured, of some thirty-five thousand pounds per annum, and in addition had recently been in receipt of about eleven thousand pounds annually from King Edward's Hospital Fund for London, the Hospital Saturday and Sunday Funds, and subscribers, leaving a deficiency in ordinary income of fourteen thousand pounds per annum. The Treasurer further reported that of the one hundred and eighty thousand pounds appealed for in 1901 on renovation and building account, only one hundred and three thousand pounds had been received to date, and that for the balance the Institution was in debt on temporary loans.

While such a position is distinctly unsatisfactory, it is not one which should stagger philanthropy. There is more than one individual in this country within whose powers it would be to supply the whole of the financial requirements above stated. But, as we have so often remarked, it is not every generation that produces a Thomas Guy, and, in the meantime, the Hospital needs

the aid of all whom these words may reach. Far be it from us to suggest that the Guy's section of the sorely tried medical profession should feel called upon to make further direct contribution, but we do ask them to continue, if possible even more ardently than hitherto, exercising those opportunities for directing the bounty of others which, in greater or less degree, are the privilege of every man whom his patients delight to honour.

As to the unique value of the influence which it is in the power of Guy's men to exercise on behalf of the Hospital, none may doubt, if the splendid result of their efforts during the appeal of 1895-96 be remembered, and it may be remarked, in passing, that almost another generation has since found a place on the Medical Register. Moreover, it should be borne in mind that, strong as was the cause of the Hospital a decade ago, that cause can justly be pleaded ten times more strongly now, seeing the strides that have been made in the efficiency and usefulness of the Institution. To take, as a test, one instance, the number of In-patients. Little more than six thousand in 1893, they had risen in 1903 to well over eight thousand, and the limit has not been reached. No mere reopening of beds could have produced a result like this. But to do justice to what has been accomplished would require a volume. Sufficient it is to acknowledge here that in a few short years, without any curtailment of or interference with the ministrations of the Hospital, there has been worked a complete revolution by which Guy's has been endowed with the power and equipment to worthily serve humanity and science for a long time to come. To provide the balance of the cost of these good things, and to secure the additional income necessary to their future preservation and full use, are ends worthy of our devoted endeavours, and we trust that during the present year the Treasurer will receive hearty co-operation towards the completion of a great enterprise.

Passim.

AFTER the rush and excitement of Christmas, the first few days of the New Year seemed colourless enough; but now that action and reaction have done their worst, it is possible to review dispassionately that eventful period. To discuss whether or no it was a more enjoyable or a more successful Christmas than those of past years, would be an idle and an ungracious task; at such times, the essential thing is the atmosphere created, and that was, as usual, warm and kindly. Guy's may be pardoned for the belief that its Christmas comes as near the ideal as that of any hospital in the Kingdom, and may well thank all those whose hearty co-operation has helped once more to vindicate so proud a boast.

DURING the year we have just entered upon, many changes will take place in the way of alterations and additions to the buildings of the Hospital. Many of these will be accomplished facts by the end of the year, whilst others requiring longer time for completion will still be on hand. To begin with, the two new theatres in the corridor on the first floor will shortly be finished, and these promise to be veritable temples of asepsis—the one with its plate-glass walls and marble wainscotting, from which even the sister is to be excluded, lotions and dressings being handed through a gap in the wall, the other with fittings equally serviceable though not so elaborate. The excellence of the new arrangements, as compared with those of the present theatres, will tend to make punctuality a pronounced surgical virtue, and, so long as the peace can be kept between rival factions, the new theatres will thus be an unmixed blessing. On the top floor, opposite Patience and Samaritan, is to be the department, the name of which may well be uttered with bated breath, for it is Actino-Therapeutic, a title the vague hopefulness of which shows the faith of those responsible in the future of the different forms of light cure.

IN the region of the Surgery the changes to be made have already been dealt with. The

Women's Shelter is rapidly nearing completion, after which the Surgery itself and the Dressers' Room will undergo transformation. Upstairs, the renovation of Luke ward will be undertaken some time this year, a temporary resting place being found for the same during the operation on the floor above. The future "Drunk or Dying" ward, which will be blessed with a less brusque title, will be in working order later in the year, whilst the extension of Cornelius in the immediate neighbourhood is to do duty as the Front Surgery during the temporary eclipse of the latter department. Last, but not least, in the far-off regions behind the Wills Library, there rest the foundations of the future Museum, which will be a tremendous boon to men of all years. A prophetic touch may not be at all amiss wherewith to cap this catalogue of facts. In the distant future, when the Museum has been completed, the more imaginative amongst us look forward to the time when the present Museum buildings shall be a mere memory, and an open space shall extend from Clinical to the wall of the Dissecting Room.

THAT most versatile of men, the Guy's Resident, has become of late so wedded to excitement that the humdrum monotony of his daily round already irks him not a little. It was only a short while ago that the Court Room rang with applause at the spectacle of his histrionic efforts, and now the same room is, like Linden, to see another sight when the band plays at dead of night, for on the evening of February 11th, the Annual Residents' Dance is to be given. As that date approaches it will be the earnest endeavour of all the more charitably minded to make allowances for those in authority, whether they hold staff or house appointments. A disposition to waltz into the theatre, to pirouette round a bed, or to discourse sweet nothings with a sister will not be met with unsympathetic grins on the part of those less fortunately placed. The ward-clerk intends to keep firmly fixed in his mind that, after all, life is one long make-believe.

IT is a fortunate thing that susceptibilities are not always easily wounded, and that the average man is innocent of any capacity for practical application of parable. A striking instance of this wise arrangement on the part of providence was afforded those who were lucky enough to be in the Smoking-room at mid-day on Saturday last. A remarkable figure in mystic attire and with long flowing hair entered suddenly a little after noon, and refusing ordinary sustenance in spite of the tempting farinaceous display upon the counter, proceeded to swallow an interesting assortment of swords, watches, etc. The only article of real nutritious value that seemed for a moment to satisfy this individual's extraordinary cravings was a simple hen's egg, generously supplied free of charge by Mr. Wade, the caterer. The latter act of kindness was responded to somewhat ungraciously, for the egg was rejected by the strange man's stomach, and returned intact to the generous donor. Attempts were made to induce this curious gourmet to try his hand (metaphorically) on the beautiful board above the mantel-piece, and upon the various dishes provided in the dining-room above, but the prophet, evidently realising that the climax of innuendo had been reached, refused to gratify these inordinate demands and an interesting display came to an end. No complaints having been made by the caterer, we suppose that he either ignored the implication or did not understand it.

CONGRATULATIONS to Mr. Watts, who has obtained the Gold Medal for Surgery in the B.S. examination, and to Mr. W. Tuohy, who secured the First Prize and Medal for Military Surgery at the London course. Both these gentlemen have the good wishes of their old friends at Guy's for their success in the future.

THE Rugby team are now playing well together, and the result is a steadily growing list of successes. Having vanquished both Northampton and Richmond, they succeeded last Saturday in defeating Catford Bridge, in spite of the absence of both McEvedy and Morgan, thereby satisfactorily paying off old scores with the latter team. Morgan is to be congratulated on his excellent play for Wales, last Saturday,

whilst everyone would like to see O'Brien and McEvedy win their International cap, for both these players, as a result of their display in the English trials, have been picked as reserve three-quarters for England.

IN three weeks time we shall once more be engaged in the Inter-Hospital Cup Ties. As holders of the Rugby Cup, our team will have to work hard to defend it, and it should not be necessary to emphasize the fact that hard training is an essential preparation. It is to be hoped that, as in previous years, a large number of men will go down to Richmond to see these matches, and support their Hospital as vociferously as ever, not only as an incentive to the team, but also because these particular matches seem to lose half their meaning unless well attended by partisans from the respective hospitals.

WE should like to draw attention to the excellent work carried on by the Guy's Hospital Ladies' Association, a letter from whose committee appears in another column. There may be some who do not know of this institution, and, if so, we would invite their early consideration of the same, for not only is the Hospital greatly benefited by the work done, but also from the social point of view the Association must commend itself to many of our gentler readers. The system of provincial branches should make it easy for all lovers of Guy's to find a most practical outlook for their enthusiasm.

THE Students' Club is much indebted to Dr. Savage for the most useful present of a new clock for the smoking-room. Besides being a very handsome article of furniture, this clock, like the boy in the Latin grammar, is of an open countenance and can be seen easily from the farthest corner of the room.

MANY are the anecdotes that could be gleaned from the Front Surgery by a careful observer of Boro' ways, and a whole book of the same might easily be compiled were it not that most of the stories therein recorded, coming as they would originally within the category of the immortal thirty-nine of Kipling, would lose the greater part of their charm in the process of editing. The following, however, is a true story, and as it is funny without being vulgar, no editing has been necessary :—

1st BORO' RUFFIAN *(referring to temperature slip)*: Wot o' mitey, wot's *your* number, moine's a 'undred an' one."

2nd B. R.: "Moine's noine 'undred and noinety-six."

1st B. R.: "Ow! Then *you'll* 'ave ter wite a *long* time 'ole son."

THE annual subscription of seven shillings and sixpence for the GAZETTE is now due and should be sent to Mr. C. H. Wells, the Secretary to the Treasurer. An Index and Title-page to the Volume for 1903 is in the press, and may very shortly be obtained at the Wills Library. Subscribers can have their sets of the GAZETTE bound in blue cloth with the Arms of the Hospital in gold, for one shilling and sixpence, by leaving them with the Librarian as early as possible.

Pass List.

Royal College of Surgeons of England.

FIRST EXAMINATION FOR THE FELLOWSHIP.

J. G. O. H. Lane.

PRIMARY EXAMINATION FOR THE FELLOWSHIP.

J. A. Andrews, J. B. Ball, G. N. Bartlett, T. H. Barton, G. Cockcroft, A. S. B. Bankhart, R. Davies-Colley, T. B. Layton, G. C. F. Robinson, W. Welchman.

University of London, 1903.

M.S. EXAMINATION.

In the Pass List of this Examination published in our last issue, omission was made of the fact that Mr. R. P. Rowlands qualified for the Gold Medal.

B.S. Examination, 1903.

EXAMINATION FOR HONOURS.

FIRST CLASS.—A. Watts (Gold Medal).
SECOND CLASS.—C. H. Robertson.

Some Causes of Uterine Haemorrhage.

BY MR. J. H. TARGETT, M.S.*

GENTLEMEN,—The subject of uterine hæmorrhage is so extensive that it would be impossible to deal with it adequately in the time at our disposal. Hence I propose to select for our consideration two or three types of cases which seem to me to present the greatest difficulty in diagnosis and treatment.

A. The first type of case shall be one of hæmorrhage occurring in very early pregnancy. I lay stress on the phrase *very early* because therein lies the difficulty. The gestation may be so early that the patient is not aware of it. It is true that she may have been irregular in her periods, but as there is no morning sickness or other sympathetic phenomena and feelings she is unable or unwilling to believe herself pregnant. Possibly, too, there may be reasons why she should not be suspected of pregnancy, and this will further complicate the diagnosis. If we turn to the various physical signs of gestation, all will admit how difficult it often is to make certain of pregnancy in the earlier months, and more especially before the eighth or tenth week. With a misleading history and doubtful physical signs, it is hardly surprising that this important condition is liable to be overlooked.

Assuming then the existence of a very early gestation, we will go on to enquire what is likely to be the cause of hæmorrhage from the uterus.

(1.) First and foremost I would place *ectopic gestation*—not perhaps the most frequent, but assuredly the most important cause from every point of view. So important is it that we are bound to have it in mind (if only to exclude it) whenever dealing with a case of uterine hæmorrhage within the child-bearing period of life.

It is now well known that when gestation occurs in a Fallopian tube it is very liable to be disturbed by the onset of hæmorrhage into the delicate tissues of the fœtal membranes, and in due time to become converted into what is termed a tubal mole. This disturbance may occur as early as the fifth or sixth week, sometimes even earlier.

I remember a case admitted to hospital in grave peril of her life from internal hæmorrhage, who had missed *no* menstrual period and had not the slightest idea that she was pregnant. Nevertheless, conception had taken place, the ovum had grown to the size of a hazel nut in the narrow inner segment of the right tube, and the rupture of its sac had caused the excessive bleeding. This had all happened in the short interval between two menstrual periods. Such a result is happily rare; in the great majority of cases a tubal mole is formed, and this in turn produces a pelvic hæmatocele, which is attended with much less urgent symptoms. These details of morbid anatomy have a direct bearing upon our subject. For when the ovum in a tube becomes seriously disturbed, it produces an effect upon the already altered lining membrane or decidua of the uterus, and this is recognised by the onset of uterine hæmorrhage. Dr. Cullingworth, in particular, has drawn attention to this symptom of tubal gestation. Such hæmorrhage is usually persistent but not profuse, and is of a dark brownish colour like that of an ordinary menstrual discharge, for which indeed it may be mistaken by the patient who knows that her period is overdue and is therefore not surprised at it. Uterine hæmorrhage of this character, accompanied with the history of missing a period, though previously regular, should always turn the attention towards ectopic gestation.

(2.) The following case illustrates another variety of hæmorrhage:—A lady's maid became secretly married to the butler on September 19th. Her last period ended on September 12th. But on October 4th, or a few days before its proper time, the period came on again and continued for several weeks. During this time the discharge was never profuse, it was rather pale in colour, and rarely contained clots. She had frequent attacks of pain in the pelvis, groins, and thighs, with some nausea and general debility. On account of the pain she consulted a doctor, who told her he thought she was pregnant but not in the right place. Owing to rigidity of the abdominal wall a bimanual examination was imperfect, but there seemed to be an indefinite swelling to one side of the uterus. I had an opportunity of seeing the case on December 16th. She was then fully 2½ months pregnant, and the breast signs indicated a progressive pregnancy. At that time it was not difficult to make sure that the gestation was intra-uterine, and the enlargement of the uterus corresponded very well with the period of possible pregnancy. However, she was still losing, and had done so almost without cessation for ten weeks. Though ectopic gestation could be excluded, it was very difficult to find an adequate explanation of the persistent

* Paper read before the South-West London Medical Society, on Jan. 13th, 1904.

uterine hæmorrhage. We may call it *decidual hæmorrhage* because it comes from the decidual lining of the uterus, and it begins so early in gestation that the cavity of the uterus is far from being filled by the developing ovum. The symptoms in this case were quite unlike those of an ordinary threatened abortion, and as the changes in the breast and uterus were progressive a carneous mole could be excluded. The possibility of a vesicular mole was considered, as in that condition a sanguineous discharge may begin very early in gestation. However, the uterus was not unduly enlarged, and vomiting was absent, as well as watery discharges. The pathology of these decidual hæmorrhages is not well understood, but it is probable that a pre-existing condition of endometritis leads to an abnormal vascularity of the decidua vera, which in turn causes hæmorrhages and subsequently abortion. It has been shown that gonorrhœal inflammation can spread from the vagina and cervix to the decidua during the early weeks of gestation, and acute intra-uterine inflammation (deciduitis) may follow attempted criminal abortion.

3. The association of intramural fibroids with pregnancy is sometimes a cause of sanguineous discharge. Whether this is due to a general hyperæmia from the presence of the tumour, or to an altered condition of the endometrium preceding gestation, the fact remains that there may be irregular and even profuse hæmorrhage during the early months of pregnancy with fibroids. In cases of fibroid polypus, sterility is the rule; but the risk of such hæmorrhage would be greater in proportion as the uterine tumour approximated to the condition of a polypus. The irregularity of the hæmorrhage and the uncertainty in identifying the pregnant uterus when it forms part of a large pelvic tumour, combine to make such cases peculiarly difficult of diagnosis.

(4.) The commoner disorders of the cervix must not be overlooked. For under the influence of the vascular changes natural to pregnancy, some forms of papillary outgrowths and "*erosions*" of the cervix more readily bleed. But reference must be specially made to carcinoma of the cervix, because of the very pernicious effect of pregnancy upon it. Owing to the softening of the tissues and the increased blood supply, the cancer advances with so great rapidity that the only hope for the patient lies in the early recognition of the disease and the speedy removal of the whole uterus. Hæmorrhage and a "dirty-water" discharge are likely to be important symptoms, but, owing to the changes above mentioned, the induration of the affected tissues is not so characteristic as in the non-pregnant state, and may even be wanting. On the other hand, the enlargement of the cervix through rapidity of the growth will probably be greater. In doubtful cases no time should be lost in deciding the question by a microscopical examination of fragments removed with a curette, or of a small wedge of tissue excised from the edge of the growth.

B. The second type of case to which I would call attention is that of hæmorrhage from the uterus after the climacteric or period of natural cessation of the menses. Such an occurrence is of the very greatest importance because it so frequently indicates the presence of malignant disease. Indeed we may go so far as to say that every case of persistent uterine hæmorrhage coming on after the menopause has been definitely established must be regarded as due to cancer until we have proved that it is not. Some of the difficulty attending the diagnosis of this condition arises from the comparative absence of physical signs other than the sanguineous discharge.

(1.) We need not consider the cases in which there is an obvious new growth or ulcer on vaginal examination. But there are two forms of uterine cancer which are liable to be overlooked. One may be described as carcinoma arising within the canal of an atrophied cervix uteri, the other is a primary cancer of the body of the uterus. In the former variety the disease is at first much concealed owing to the disappearance by atrophy of the vaginal portion of the cervix, which naturally follows the change of life. Under such circumstances there may be very little to see with the speculum. But on careful bimanual examination some induration or increased thickness of the supravaginal cervix will be detected, and an attempt to pass the sound is likely to cause free bleeding. For confirmation small fragments of tissue removed with a curette from the inside of the cervical canal should be examined microscopically. Pain and wasting may be absent in the early stages of this disease.

(2.) When the cancer has originated within the body of the uterus, neither inspection nor palpation of the cervix are of much value for diagnosis. Here we must depend almost entirely upon the results of exploration of the uterine cavity with the sound or finger, and of the microscopical examination of the curettings. From an exceptionally large experience of the morbid anatomy of curettings I can testify to

the value and reliability of this mode of diagnosis; at the same time I am aware of occasional fallacies. The following case illustrates one of them:—

A lady, æt. 55, the mother of several children, came under my care for uterine hæmorrhage. She had passed the menopause some two years, and had kept quite well until six months previously, when somewhat suddenly a sanguineous discharge came on and continued with very short intermissions. Latterly the discharge was more watery than blood-stained, but was never offensive. There was considerable backache and abdominal tenderness, but no obvious loss of flesh. Some three months before I saw her she had consulted a specialist, and upon his advice the cervix was curetted and cauterised. The material removed was submitted to an eminent pathologist for microscopical examination, and was pronounced innocent. As nothing could be made out from bimanual examination beyond a slight enlargement of the uterine body, the patient was again anæsthetised and the cavity explored. Much soft white growth was readily removed which needed no microscope to demonstrate its nature. My explanation of the apparent failure of the pathologist is that the material submitted to him was not truly representative of the diseased tissues, but was derived from the cervical canal or some region beyond the limits of the growth.

(3.) Another lesion which may provoke persistent hæmorrhage after the menopause is a vascular polypus of the cervix uteri. I have recently seen two cases of this kind, and one of them was suffering from severe anæmia and debility in consequence of the prolonged bleeding. She was 55 years of age, and the menopause probably occurred at 52. But owing to much irregularity of the periods about that time, followed by hæmorrhage due to the polypus, the patient was under the impression that she had *not* passed the change of life, and that her present trouble was of that nature. She had therefore been under treatment by medicines, rest and hot douches for many weary months, until she was practically confined to her bed. A small soft polypus could be felt in the site of the atrophied cervix, and as it seemed incredible that this could be the sole cause of the hæmorrhage, the uterus was carefully explored under anæsthesia. The polypus was thoroughly removed, together with one or two smaller projections within the cervix, but the cavity of the uterus was found to be healthy, and the endometrium had become atrophied. The operation was followed by a complete cessation of the bleeding.

(4.) Under rare circumstances a post-climacteric hæmorrhage may be due to malignant disease of the ovaries, or Fallopian tubes. I have only met with this condition once, in a patient of advanced years who had long passed the menopause. The hæmorrhage was by no means profuse, but there was a constant reddish-brown discharge. Vaginal examination revealed a hard uneven mass on one side of the pelvis to which the atrophied uterus was fixed, and at the bottom of Douglas's pouch several small nodules were detected, indicating a secondary infection of the peritoneum. The patient's chief complaint was severe backache which kept her awake at night; there was also much pain from the action of aperients and from the use of enemata—probably due to the deposit of growth upon the serous surface of the sigmoid and rectum. The end was slow and very distressing.

At the necropsy there was a scirrhus carcinoma affecting both ovaries, with diffuse infection of the peritoneum, and ascites. But there was no large abdominal tumour, and the character of the lesion therefore differed much from that of the ordinary malignant ovarian cyst.

C. The third variety of uterine hæmorrhage which I have selected is that arising from a general disorder of the patient. This, by itself, is a very wide subject, so we will limit our consideration to two or three points only.

(1.) The bad influence of alcoholism upon women, no less than men, must be admitted by all who have had much experience in general practice. That it is a direct cause of menorrhagia, and ultimately of irregular uterine hæmorrhage, there can be no possible doubt. The effect of this frequent and prolonged hæmorrhage is to induce feelings of weakness and exhaustion, for which more stimulants are taken, and thus a vicious circle is set up. I shall not, however, pursue this thorny subject further than to express an opinion that women in health very rarely need alcohol of any kind, and that the giving of alcohol for painful menstruation, whether in the young or middle-aged, is in most cases a highly dangerous and reprehensible practice.

(2.) In the course of my routine pathological work, I have on several occasions met with specimens of uterine curettings which showed marked degenerative lesions in the vessels of the endometrium. These changes consist in thickening of their coats, with much hyaline or fibroid degeneration, and considerable diminution and

even obliteration of the lumina. In fact, the condition corresponds with that known as arterio-capillary fibrosis, so frequently associated with chronic Bright's disease. A few weeks since, in reporting on such a specimen, I called attention to the state of the vessels, and suggested the existence of Bright's disease. Some days later the doctor very kindly wrote to me saying that he had been called to the case (a middle-aged woman) for the first time on account of severe uterine hæmorrhage, and that he had curetted her at once. After receiving my report he had examined the urine on two or three occasions, and found that the patient was passing a large quantity of pale urine, of low specific gravity (1012), with a trace of albumen now and then, and a few hyaline casts. The pulse was of decidedly high tension, and he therefore had no doubt that she was suffering from chronic Bright's disease. Under such circumstances there may be a temporary improvement from the operation of curetting, but experience shows that the symptoms are very apt to recur.

(3.) But apart from Bright's disease, there is a condition of enlargement of the uterus which seems to me chiefly dependent upon the above-mentioned arterio-capillary fibrosis. It has been termed chronic hyperplasia of the uterus, and is characterised by a very considerable, but uniform enlargement of the whole uterus, especially of its muscular walls. By some writers it is described as chronic metritis, and is attributed to subinvolution, or chronic endometritis following repeated labours. Such an explanation is no doubt true of many cases, but I venture to think that there are others to which it will not apply.

Among the specimens now exhibited is the uterus of a single lady, æt. 38, who had suffered from gradually increasing menorrhagia and dysmenorrhœa for several years. There was not the slightest suspicion of any gonorrhœal or septic infection. As medicines and curetting had failed, the uterus was removed. It will be observed that there is a very marked degree of general hypertrophy of the organ, the wall measuring over an inch in thickness at the fundus. Microscopic sections reveal a diffuse fibrosis, the bundles of unstriped muscle being separated by much hyaline fibroid tissue. The vessels are also much degenerated, as in arterio-capillary fibrosis.

Now, though this patient was not known to be suffering from chronic nephritis, yet I would suggest that these changes in the uterus were merely the result of a general vascular deterioration, and that perhaps in this instance the uterus had suffered instead of the kidney. There are two other organs in which an allied condition is met with. Occasionally in young women an extensive fibroid induration of the breast occurs, without any preceding symptoms of inflammation or obstruction of ducts. This is a prematurely senile degeneration of the gland, and is probably the result of diseased vessels. Similarly in the ovary a state of sclerosis with marked atrophy is sometimes found in women of 30 to 35 years who suffer from intense pelvic pain. In such specimens I have found severe endarteritis, leading to obliteration of the vessels and a fibroid condition of the cortex of the ovary.

Turning to the clinical aspect of these cases of chronic hyperplasia, it may be said that frequent hæmorrhage is usually the chief symptom. Drugs and curetting, however, are both liable to fail, though some benefit may at first be obtained. Such measures should of course be given an adequate trial, and careful investigations as to the existence of nephritis should be made. But if ultimately the case seems likely to drift towards permanent invalidism, through hæmorrhage and constant pain, then the question of removal of the uterus may be justly considered.

In conclusion, let me express the hope that the many interesting points in the medicinal and general treatment of uterine hæmorrhage, which have been unavoidably omitted, will now receive full discussion at the hands of this meeting.

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Wednesday, January 21st and 28th, 1.30 p.m., Clinical Surgery, by Mr. Jacobson.

Saturday, January 16th, 23rd and 30th, 1 p.m., Clinical Medicine, by Dr. G. Newton Pitt.

Monday, January 18th, 1.15 p.m., Lecture by Mr. Higgens.

Monday, January 25th, 1.15 p.m., Lecture by Sir Cooper Perry.

Presentation.

Dr. W. WHITWORTH, of St. Agnes, Cornwall, has been presented by the members of the Miners' and Mechanics' Institute with his portrait, in recognition of his valued services as honorary secretary of the institute for twenty-one years. Dr. Whitworth, after acknowledging the gift, presented it to the institution.—*British Medical Journal.*

Guy's Hospital Massage Classes.

LESSON I.

Definition and Theory of Massage. Classification of Movements. Demonstration and Practice of Effleurage.

LESSON II.

Demonstration and Practice of Petrissage, etc.

LESSON III.

Demonstration and Practice of—1. Tapotement. 2. Vibrations. Massage of Upper Limb.

LESSON IV.

Massage of Lower Limb.

LESSON V.

Massage of Chest and Abdomen. Manipulations for Constipation.

LESSON VI.

Massage of Back.

LESSON VII.

Massage of—1. Head. 2. Face. 3. Neck.

LESSON VIII.

1. Lateral Curvature. 2. Flat Foot. 3. Sciatica.

LESSON IX.

Massage of all Joints. Writers' Cramp. And other diseases which it may be found necessary to demonstrate.

LESSON X.

General Massage.

LESSON XI.

General Massage. Manipulations for Obesity.

LESSON XII.

Remedial Gymnastics.

Can a Resident Keep Fit?

IN the Medical and Surgical Reports of the Boston (U.S.A.) City Hospital for 1903, there is a suggestive article by Wm. R. S. Emerson, M.D., on the health of the home officers or residents of that institution. From September 1, 1895, to July, 1903, close records have been kept of all the cases of illness among the home officers, which have necessitated their going off duty for a day or more. The tabulated results are too complete to quote in full, but taken together the results show that among the officers on the medical side there were thirty-three cases of illness, and on the surgical side there were thirty-four cases of illness in that period. The most frequent cause of indisposition in both departments was tonsillitis, there being twelve cases on the medical and eight on the surgical side. Influenza accounted for four on the medical side and furunculosis for four on the surgical side, and other conditions such as gastro-enteritis, on the medical, and septic arms, hands and thumbs, and appendicitis on the surgical, caused about two cases each.

Taken broadly the table shows a greater number of nasopharyngeal and febrile affections on the medical side, and of local septic infections on the surgical side.

In the infectious or south department there were at the same time thirty cases of diphtheria, ten cases of scarlet fever, one of measles, one of varicella, and three of mumps.

These figures calculated out as percentages give the following results:—

Average number times sick per Home Office Yearly for the past seven years:

Medical	Surgical	Contagious.
·7	·5	1·4

which are about what one would expect from experience at this hospital of residents' illnesses.

The article then proceeds to discuss the relation of exercise* to the health of residents, who, as here, are to a great extent confined within bounds.

In 1899 two excellent tennis courts were built by the governors, and a year later the trustees, aided by generous contributions from the visiting staff, installed two squash tennis courts and equipped them with electric light. Shower baths were also supplied, and these arrangements have offered an excellent opportunity of obtaining, within the hospital grounds, sufficient exercise practically in the open air, with means for a proper bath and rub down afterwards. The tabulated results are as follows:—

Medical.—Number of men taking systematic exercise, 13. Condition at end of service, good 12, fair 1.

Number of men taking occasional or practically no exercise, 29. Condition at end of service, fair 16, stale 13.

Surgical.—Number of men taking systematic exercise, 1. Condition at end of service, 1 good.

Number of men taking occasional or practically no exercise, 41. Condition at end of service, good 6, fair 11, stale 23.

By *good* is meant general health excellent, weight normal, and fit to repeat service. "Feel fine, never better in my life."

By *fair* is meant tired but able to do his work well.

By *stale* is meant under weight, appetite poor, having nervous disturbances. "I was done," "Fagged out," "Didn't get into good condition for months."

Since the establishment in 1899 of the above means of exercise, the health of the Boston City Hospital has greatly improved, the percentage of sickness having dropped from 1·1 in 1889 to ·5 in 1903.

The article concludes, "It should be urged upon home officers that the sense of fatigue occurs most often in the hospital as the result of nervous tension and indoor air rather than to muscular exhaustion, and is therefore relieved by proper exercise and baths, and that the reasons offered for insufficient time to take systematic exercise at least three times weekly are plausible rather than real."

The moral of this article for residents at Guy's, with a squash court, a gymnasium, and a swimming bath, is obvious.

*By systematic exercise is meant the obtaining of exercise at least three times a week; sufficient in amount to cause free perspiration and followed by a rub down.

Guy's Hospital Dental Society.

THE Society begs to acknowledge two very interesting casual communications from Mr. J. J. Jiménez, L.D.S., who is practising at San José, Costa Rica.

(1.) This was a case of periosteal sarcoma of the right maxilla, which had been operated upon. A denture was made to relieve the distress of the patient when taking food. Mr. Jiménez sends models, and a duplicate of a vulcanite case the patient is at present wearing. The patient was seen a year afterwards, and he was perfectly comfortable.

(2.) This was a case of retention of the temporary canine, and late eruption of the permanent canine in the palate of a lady, æt. 25. The temporary was extracted, and the permanent tooth pushed out by means of piano wire on a vulcanite plate. Three models show the excellent result.

South African Memorial Account.

RECEIPTS.

1903.		£	s.	d.
Sept. 30.	To Donations received to date ...	276	10	6
	,, Grant from GUY'S HOSPITAL GAZETTE	4	8	9
		£280	19	3

EXPENDITURE.

1903.		£	s.	d.
Sept. 30.	By Amount paid to Builders, as per Architect's Certificate	249	6	0
	,, Architect's Fee	21	0	0
	,, Printing, Postage, and Advertising expenses	10	13	3
		£280	19	3

Audited and found correct by,
(Signed) M. G. LOUISSON,
Auditor to the Club's Union,
January 11th, 1904.

Change of Address.

Dr. C. Edwards, from Shooters Hill Road, Blackheath, S.E., to Watersmeet, Ilfracombe.

Mr. Edward Farrant, L.D.S., from Hemyock, Devon, to 52, High Street, Wellington, Somerset.

Dr. J. A. Howard, from Herne Hill, to 40, Harold Road, Upper Norwood, S.E.

Dr. W. H. Maxwell Telling, from 7, Park Square to 32, Park Square, and 5, Lifton Place, Leeds.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Correspondence.

Massage Classes.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—You very kindly referred to the scheme for the formation of Massage Classes in a recent issue of the GAZETTE. These classes are now being held, and some further particulars may be useful to past and present students.

Tuesdays and Thursdays at 4.30 p.m. is the time fixed for the present course, and members meet in No. II. Class Room in the Physiological Buildings.

A fee of £1 1s. is charged to cover the expenses of instruction, models, apparatus, etc.

The class is limited to eight in number and the number of lessons to twelve.

I enclose you the Syllabus, and I shall be pleased to receive the names of any Guy's men who care to join the next class which will be formed shortly.—I remain, yours truly, ARTHUR W. ORMOND.

Jan. 13th, 1904. Hon. Sec. Students' Club.

Guy's Hospital Ladies' Association.

DEAR SIR,—We should be much obliged if you would allow us once again to draw your readers' attention to the work carried on by the Association.

H.R.H. Princess Christian has consented to become President of the Association, and the committee is anxious to mark appreciation of Her Royal Highness's kind interest by being able to report to her a largely increased membership during her first year of office. The Association has been most generously supported by the wives of many old Guy's men, and we feel sure that among the students at present attached to the hospital, there must be a large number whose relatives would be glad to help in our work.

The Association is composed of a main body, and of a number of local branches scattered throughout the country. Its functions are: To provide clothing for patients in the hospital or on their discharge to convalescent homes; to contribute funds to support beds; and to arrange for members to visit the patients in the wards. In all of these directions additional help is urgently required.

The committee would particularly welcome the formation of local branches in new districts, as they consider this the most satisfactory method of expansion. Any information and copies of the Report will be gladly supplied on application to the Hon. Secretary, Guy's Hospital, S.E.—We are, Sir, yours faithfully,

EDITH BENYON, *Chairman*.
MABEL G. BONSOR, Vice-Chairman.
S. A. SWIFT, Matron.
E. GERTRUDE PYE-SMITH, Hon. Treasurer.
MAY H. SHAW, Hon. Secretary.

Jan. 12th, 1904.

To The
Medical School
OFFICE

Physical Society.

Discussion on Cancer.

THE sixth meeting of the society was held on Saturday, December 19th, in the smoking room, Mr. Blake-Odgers, M.B., B.Ch., F.R.C.S., being in the chair. There were fifty-three members present.

The evening was devoted to a discussion on cancer which was opened by the President and five other members, who each brought forward a special aspect or department of the subject.

The PRESIDENT said that in introducing this discussion three things impressed him chiefly: in the first place, the importance of the subject. No matter in medicine or surgery had ever aroused such almost feverish excitement among the laity as this question was doing to-day. One could scarcely pick up a daily paper without finding some new theory of its causation upheld, or some equally marvellous cure advocated. Secondly, he could not but congratulate the society on the gentlemen who had consented to read papers, and to thank them for coming forward at such short notice. The third fact that struck him was the extreme difficulty—he would almost say the hopelessness of their task—for "cancer" must include sarcoma as well as carcinoma, while any theory of the cause of cancer to be sufficient must explain the origin of benign neoplasms also: simple and malignant growths are too closely connected both clinically and histologically to admit of separate theories of their causation.

With regard to the different explanations that had been advanced, until the parasitic theory had been placed on a more solid foundation, one had to fall back either on Cohnheim's embryonic residues or on persistent intermittent irritation as the cause of cancer. While each of these explained severally different groups of cases, to find the common cause one must look for the common factor. Such a factor had been considered by Riphert to be an alteration in the relation between the epithelial and connective tissue elements of a part—an alteration in the "tissue tension." More satisfactory was it to refer it to some abnormal metabolism of the individual cells whereby the normal relation between anabolism and katabolism was upset; the former preponderates and the existence of the cell becomes purely vegetative and of no value to the physiological common weal. As in any human society it is those out of work who at once do the most damage and also procreate their kind the most rapidly, so such cells thrown out of employment may be the cause of cancer and be in the "pre-cancerous" stage.

Such "unemployed" cells may arise:—

(*a*) From sudden cessation of function, *e.g.*, the chorionic villi put out of action by an abortion, may grow vegetatively, setting up first a myxoma of the chorion, r secondly, possibly a malignant deciduoma.

(*b*) From fœtal residues.

(*c*) As the result of chronic inflammation and the hyperplasia resulting therefrom — *e.g.*, epithelioma occurring on the top of chronic superficial glossitis: sarcomata arising from the cells formed in the union of fractured bones, or as the outcome of osteitis deformans.

Mr. MOLLISON, B.A., on "The Embryonic Theory."

Cohnheim supposes that in the development of the embryo more cells are produced than are used to form the various organs, this probably taking place at a very early date, between the differentiation of the blastodermic layers and the full development of the embryonic rudiments; and further, these superfluous cells may be distributed more or less equally over the whole of one of the rudiments or may be confined to one spot in a rudiment.

I wish here to make a slight digression to refer to experiments which show the great activity possessed by embryonic cells; and this is, I think, a very strong argument for this theory and should be carefully considered.

These experiments were those of Zahn and Leopold. These observers found that scrapings of epithelial cells and pieces of tissues from young animals—even a few days old—when transplanted into other animals, into the antechamber of the eye, peritoneum, and so on—only grew quite a short time and were gradually absorbed; but now if the scrapings were taken from a fœtus in utero, they grow when transplanted to many hundred times their own size, and remained as long as the animal lived, and in some cases formed actual tumours—the tissue used was cartilage as being easily distinguished, and it was found that enchondromata were formed.

These experiments prove absolutely that embryonic cells have very special powers of multiplication, and if embryonic tissues when taken from their natural position, cut off from their blood supply, and put into a new position can yet grow, how much more is it possible that they should grow when left *in situ*. Now is there evidence for supposing that rudiments do exist in the body? Yes. Actual remains have been found.

Virchow, previously to Cohnheim, demonstrated the presence of cartilage germs in adult bone, especially in rickety subjects—in the lower end of the femur quite apart from the articular cartilage; also in the terminal phalanges. The fact that these rudiments do not grow at once is no argument against the theory, for there are several instances of latency in development that occur normally in the human subject. Teeth, skin and its appendages—the mamma and the larynx do not develop fully till puberty; the uterus, too, does not develop fully unless stimulated by passage of an impregnated ovum. So, too, certain tumours do not occur till puberty—adenoma of breast, myomata of uterus.

It is true that Cohnheim admits there is little or no positive evidence for his theory, but points out that so many otherwise baffling phenomena and difficulties in the etiology of tumours are explained if we accept his

hypothesis. Thus it explains *site, hereditary transmission, congenital appearance, heterologous growths* and *structure.*

1. *Site.* — Tumours appear in positions where development has been complicated, where we might expect embryological remains and irregularities, and where one kind of epithelium changes to another, and it may be supposed that some cells were left behind. There are many examples: cancer of lips and tongue, of rectum where hypoblast and epiblast meet at the involution of the proctodeum; of cardia and pylorus, of prostate, where Müller's ducts open into urogenital sinus; and of œsophagus opposite bifurcation of trachea where it opened primitively into trachea.

2. *Hereditary Transmission.*—Many cases are known. I will mention a few. Friedreich had a unique case where a carcinomatous mother had a child with carcinoma. The tumours are not always of the same nature, nor in the same position in parent and child, but they may occur in the same "system"; thus enchondromata have been found in various members of one family on various bones—pelvis, humerus, ribs, &c.

3. *Congenital Appearance.*—Teratomata, lipomata, fibromata, adenomata of kidney, rhabdomyomata of heart.

4. From *heterologous growths* the strongest evidence is obtained in support of the theory. Thus, in the lungs, bony tumours originate in cartilage remains from formation of the tracheal rings. In the parotid region bony tumours arise from cartilage remains of Meckel's cartilage. In the urogenital system cartilage and muscle are found, only to be explained from development. The mesonephros developing from near the parts which also form the primitive vertebræ, and the sarcomeres the primitive muscle plates.

Another case, which occurred recently, can be most convincingly proved by Cohnheim's "rests." The case was one of a carcinoma of the liver, with a mass on the vertebral column—about the fourth dorsal the liver mass was taken as primary with secondary mass in the vertebræ; this being considened a very extraordinary sequence of events in the light of our knowledge of growths generally. But now look at the case from a developmental point of view. Gaskell has shown that the central canal of the spinal cord is most likely the primitive gut; so the vertebral growth, which had the structure of a carcinomatous secreting gland, I look upon as primary from the rudiment of a gland connected with the primitive gut, and the liver growth a normal secondary deposit.

5. *Structural* peculiarities are explained. The best example of this is a myxoma of the subcutaneous tissues. Mucoid tissue is that first produced by the embryonic cells on the way to fat and colloid formation. Now it is most unlikely that adult subcutaneous tissue should revert to mucoid. But if remains of embryonic cutaneous tissues were present, the first stage in its development would be mucoid, hence a myxoma.

After showing that these facts add much weight to his theory, Cohnheim says that still we have no definite evidence as to what causes the rudiments to start growing.

He suggests that altered blood supply may play a large part, and points out that little is known about the blood supply of tumours. He instances the fact that adenomata of breast and growths of the ovaries always increase during pregnancy.

I will refer briefly to the Bradshaw Lecture by Mr. Henry Morris, in which he reviews the various theories, and upholds Cohnheim's theory, for which evidence is increasing with every advance of embryology.

Finally, he points out that if Cohnheim's theory is correct, work done on other lines is practically wasted, since cancer is inevitable.

Mr. BOWEN, M.B., F.R.C.S., on "Irritation as a Cause of Cancer."

The honour has fallen to me this evening of introducing to you the principal points which have led to malignant or atypical epithelial growth being regarded as the result of some irritant. I do so with some diffidence, not only because the whole question of malignant disease is at present *sub judice*, but also because when we have sifted all the evidence put forward and have tried to convince ourselves that the marshalled facts explain why we should have confidence in such a belief, a truthful spirit compels us to acknowledge that at the very most we have collated a few interesting records, and that our explanation of the same may be open to doubt if not denial.

We have in the present day arrived at a power of diagnosis which leads a man comparatively early in his career to say with some confidence that this tumour is malignant and that is simple. Further, if some tumour is separated from its surroundings and put before him as a pathological specimen, he can still differentiate in many cases between the typical and atypical. You may show him beneath the microscope two specimens from the same organ, and apparently of the same organic arrangement, yet again he will eliminate the dissimilar points which may make the difference of life or death to a human being. But it is when you come to the why? or ask how? that the most careful observer, the skilled pathologist shakes his head, discusses theories in the abstract, and wisely refrains from putting faith in any.

To-night, however, we have left, to a great extent, the field of exact science and pass into the limitless regions of the problematical, determined and united however on one point; and that is, that all the facts known shall be interpreted to the entire support of the different theories which we each separately advocate. Hence, supporting as I do that theory which says that irritation is responsible for cancer, I shall endeavour to show in the short time at my disposal, that there are many points which favour this view, and these I shall discuss under the following headings:—

(1) The part that irritation plays in disease as a whole.

(2) The sites of cancer.

(3) Predisposing factors.
(4) The nature of the irritant.

Considering the first heading, viz., the part irritation plays in disease as a whole, we are struck at the outset by the fact that of the two great groups of pathological conditions—inflammation and new growths—the former has been proved almost conclusively to be due to the result of irritation leading to cell proliferation, and it is a fact that, as our enquiries have extended further and further, morbid changes, which in the past have been looked upon as tumours, have more recently been passed over to that increasing class, the granulomata.

We must remember that inflammation is associated with cellular exudation and that we know as far as investigations have reached, that this cellular increase means cellular production, for we find that in most inflammatory conditions with exudation locally there is associated general leucocytosis. That I think may be considered as the keynote of irritative lesions, an increase of cells de novo.

I pass on to the second heading, viz. :—"The Sites of Cancer." It is here that those who favour my theory hope to strengthen their position. Seeing that I cannot discuss the points as fully as I would wish, I give but a passing notice to those rarer sites, the scrotal cancer in chimney sweeps, epithelioma occurring on the arms of those who work with paraffin, the commonly accepted belief that epithelioma of the skin starts in scars which, badly nourished with blood, devoid of nerves, unsupplied with lymphatics, are particularly prone to suffer from the effects of any irritant; epithelioma of the gum associated with a badly-fitting tooth-plate; cases such as Mr. Jacobson has described to us, where the cobbler who held his last between his teeth, thus letting it rest on and irritate his lips developed epithelioma at the site of irritation, or the case where one who, unused to smoking, on one occasion took up a churchwarden pipe, which, abstracting moisture from the lip tore the epithelium from the surface, and shortly afterwards developed a malignant focus at that spot. Merely mentioning these I pass on to the commoner sites of growth and call your attention to the association of epithelioma penis and phimosis associated with balanitis, and to the great etiological factor in cancer of the tongue, syphilis, associated with its ulceration and fibrosis keeping up constant irritation; whilst again we know the association of a jagged tooth and a growth on the side of this organ.

I have mentioned one carefully examined case where the lip became the site of growth, but I may remind you that Sir Thornley Stoker has recorded that of 350 cases of cancer of the lip only three occurred in women, and these "smoked assiduously."*

We have yet to prove the close connection between carcinoma of the breast and badly-fitting corsets, but I may call your attention to the association of the prominence of the breast in women, the closely bound, often unyielding body support, and the prevalence of cancer in this organ in the one sex.

Cancer of the cervix uteri, one remembers, occurs in multipara often in association with injury during parturition.

Strong support is also given by the common sites of cancer in the alimentary canal. Fairly common in the œsophagus, it usually occurs at one of three positions; two of these, viz., at its origin opposite the cricoid cartilage and its termination where it joins the stomach are the two narrowest parts of the tube, whilst the third common site, *i.e.*, at the point where it is crossed by the left bronchus may perhaps be explained by the fact that normally existing only as a transverse slit when food passes down, it has to raise a comparatively rigid tube before it can pass.

When, however, we come to consider the usua positions of cancer of those parts between the cardiac end of the stomach and the termination of the rectum, we are struck by the fact that, whereas carcinoma ventriculi is the commonest situation in which cancer is found in man, and carcinoma of the sigmoid and rectum are also very common, yet that that large portion of the alimentary canal lying between the termination of the pyloric portion of the stomach on the one hand, and the ileo-cæcal valve on the other, is almost free from this disease. How often do we meet clinically with a case of growth of the small intestine? How seldom do we meet with a case of acute obstruction from this cause? Mr. Bland Sutton has stated that of all malignant growths of the intestine but 2 per cent. affect the lesser bowel, and this refers to the intestine alone without reference to stomach or œsophagus. That is to say that 98 per cent. occur below the ileo-cæcal valve.

Does our theory of irritation explain this? No theory I venture to assert will explain it better. More or less solid food is found in the stomach, more or less solid fæces are found in the great intestine. When food passes the pylorus it is a semi-fluid mass, and when it reaches the ileo-cæcal valve, whatever its changes in chemical composition may have been, it is still in its semi-fluid condition. This is the statement of a fact, and I explain it on what appears to me to be the simplest laws. A hard body does more harm to a soft structure than a soft one, the wearing process is more appreciable, the irritation greater, and I ask you to remember that this is a process that does not go on for a week, nor yet a year, but for life.

Mr. CAMERON B.A., on "The Infectivity of Cancer."

It is nowadays recognised that all disease which is infective is parasitic in origin. If any disease is placed on sure proof under one category its admission into the other is implied. The proof that a disease is infective depends upon those dull and dry things, statistics, and cancer statistics are as dull as the rest; nevertheless, in view of the prolonged failure of work in the laboratory, they have gained an enormous if accidental importance. It is to them that we must look for our strongest argument against the rival theories which are entirely

* On Cancer of the Lips. *Practitioner*, May, 1903.

empirical, invented to explain known facts and dependent for their success upon the ingenuity with which they are extended, I will not say twisted, to meet all cases.

In the first place statistics prove that cancer has a well marked geographical distribution. Now such a well marked regional distribution itself entails belief in a specific cause. On no theory, other than that of the parasitic origin of cancer, can we account for the fact that cancer is comparatively common in one place and something of a rarity in another. We cannot believe that cell rests are more common in one place than in another, or, if we are to understand that these evidences of slip-shod workmanship occur in each and all of us, we cannot believe that such considerations as climate, geological formation, rainfall, height above the sea level, can determine that they should remain quiescent in one county and have their wicked way in the next.

The advocates of this theory have been reduced to the suggestion that the variable quantity, the stimulus to these embryonic remains is supplied by anything which tends to lower the vitality generally—insufficient food, insanitary surroundings, excess of work. But statistics show that cancer is equally common among rich and poor. They have, therefore, come to the positively astounding conclusion, that the poor are cancerous because of bad food and insanitary conditions; whilst the rich, who on this showing certainly ought to escape, fall a prey because of worry and mental strain—reasoning which reminds one of the classification of books into quartos, folios, and books of reference.

The theory of irritation is not more successful in explaining these wide variations in the incidence of cancer. For instance, we are told that cancer of the rectum is so common because the intestinal contents there are so very irritable, an explanation which at once suggests the question as to how geographical considerations can possibly influence any fact, unhappily so universal as the irritability of fæces. For variations so wide only one theory will satisfactorily account, that of the parisitic origin of cancer, and all other theories are reduced at once to the subordinate position of predisposing contributory causes, necessary perhaps to prepare the soil, but of themselves incapable of causing the growth.

Secondly, these dull statistics may be made use of in the search for the micro-organism itself. Logicians have a way of puting obvious facts very concisely, and somewhere at the beginning of most books on logic, there is set down this piece of wisdom—that, in a series of instances, the sole invariable antecedent circumstance must be the cause or an indispensable part of the cause. If only statistics are full enough, if only cases are examined from all possible points of view, the one circumstance which all areas of high cancer mortality have in common, and which must be an indispensable part of the cause, will ultimately be discovered. It is a method of research which has isolated many of the agricultural pests; the disease of wheat known as rust was a mystery until the common factor was found in the propinquity of barberry bushes. Moreover, it is the method which was successful in isolating the tetanus bacillus. Lockjaw was as mysterious in its workings as cancer, until it was found that all cases of tetanus had this in common, some connection, direct or remote with the soil, and it was in the soil and not in the lesion that the bacillus was found. Cancer statistics have only recently been studied from this point of view. Mr. Havilland years ago expressed the opinion that cancer was common in low-lying river valleys with alluvial soil, and rare upon high ground and on igneous rock, and made the observation that a cancer map was the direct opposite of a tubercle map, where one was common the other was rare. Recent work has tended to disprove both statements. Cumberland follows immediately after Huntingdonshire and Cambridgeshire as the most cancerous of English counties. The death rate in the Thames Valley is very high, whilst the counties surrounding the Severn Valley have the lowest mortality of all. The most recent work based upon the statistics published by the various European governments, as well as those of Australia and the United States, seems to show that only one geographical feature is of importance; in nearly every case an area with a high cancer mortality is a forest area, incidentally with a good water supply. It is a conclusion based upon a most exhaustive research, and it is rendered doubly interesting because it exactly coincides with the results obtained by investigators working along quite different lines, I mean in connection with cancer houses and cancer villages. Almost all these remarkable instances of houses and villages which seem to have become simply infested with cancer, have this in common they are densely surrounded by trees, and are situated in damp ground. It is useless to quote examples of the apparently epidemic attacks of cancer because time is short, and any single instance could be brushed aside as coincidence. At the present time among all the phases of cancer investigation, research upon such lines, whether with the wider prospective of large geographical areas, or with the attention focussed upon individual cancer spots, seems most logical and most full of promise.

A study of cancer from a clinical point of view tends to the same conclusion and forces comparison with other infective diseases. The lesion is at first circumscribed. Once generated it spreads locally, then becomes disseminated metastatically along the blood and lymph channels until finally death is due, not to the local lesion, but to a generalised infection, loosely called cachexia. A cancer of the breast, a condition which cannot interfere with the intake of food, which causes perhaps relatively a small amount of pain, and which, if ulcerated, is kept so clean as to prevent any considerable amount of septic absorption, with few secondary deposits or none, is responsible for death only in the sense that the solidified lung is responsible for a fatal ending in a case of pneumonia. Surely it is reasonable to suppose that in both the infection is general, that in both the lesion represents only the point of manufacture of the toxin.

Finally, as students of medicine, we have to remember that upon our belief in the infectivity of cancer rests our

hope of ultimately discovering a remedy. No parasite, no cure, should be taken as the motto of all cancer research, lest in despair we are tempted to give up work altogether and spend the rest of our time at play with embryonic remains, the tension of tissues, and the inherited vitality of cells.

Mr. C. H. ROBERTSON, M.B.B.S., on "The Parasitology of Cancer."

First of all it would be well to review the points which would seem to indicate that cancer is an infective disease :—

A. Local appearances.

(1) Round-celled infiltration, most marked at actively growing parts of tumour.

(2) Metastases.

(3) Only one primary growth.

(4) Commonly arises at sites of irritation ; *cf.* tubercular joint.

(5) Effect of light; *cf.* tubercle.

(6) Presence of so-called parasite in many of the cells.

B. General considerations.

(1) Once started, rapidity of progress.

(2) Occurs chiefly in elderly people, *i.e.*, those with poor resisting power.

(3) The profound cachexia found in later stages.

(4) Cancer houses.

These houses are situated in low-lying, well watered districts, and of many houses in such a district, those will be affected which are nearest to a large quantity of water, *e.g.*, a river.

Cancer has been proved not to be due to drinking water, or to heredity, for such people as servants in these houses become affected with cancer in the same way. It may be noticed that these houses occur in districts which were at one time malarial and now have become cancerous. In Italy, where malaria is prevalent, the mortality from cancer is extremely low. I think that from this peculiar relationship of cancer to malaria it may at least lead one to *consider* whether cancer may not be due to a parasite of a somewhat similar nature to malaria.

The *Parasite.*

Virchow many years ago described spaces found in cancer cells ; these may or may not have been due to the method of fixing.

Russell, in 1890, first described what he termed "fuchsine" bodies in the cells; he so called them because they were not decolorised with the rest of the section when treated with decolorising agents.

Ruffer, in 1892, described very carefully sections of cancer, the cells of which contained these bodies, which Metchnikoff called "parasitic protozoa."

The opponents of the parasitic theory have said that these bodies are the result of degeneration or arise in the fixing of the slide. That this cannot be, is proved by the following :—

(1) They can be seen in the fresh juice.

(2) Staining reactions differ from those of cancer cells.

(3) Found, not in parts of growth undergoing degeneration, but in growing parts.

(4) Have never been found in other than cancers, *e.g.*, gummata or tubercular deposits, both of which degenerate as part of their life-history.

(5) More parasites found in more rapidly growing cancers.

The parasite is a rounded body with a well defined capsule. There is a central dark body which does not give the characteristic reactions of a biological nucleus. It seems to multiply by budding. It is most often found in the cell itself with the nucleus of cell pushed to one side.

Does this fulfil the postulates laid down by Koch, which shall prove the organism to be the cause of the disease? Yes, because—

(1) Only found in cancers.

(2) Plimmer says he has found it in every case, except those much degenerated growths.

(3) Cultivations have been made by growing anaerobically.

(4) Animals injected with the culture have occasionally died of endothelial growths ; but if the culture be rubbed on the cornea, epithelial proliferation always follows.

In concluding these short notes, I would like to point out that this is the only theory that has been worked out in the laboratory, the other theories are much more in the air, *e.g.*, Cohnheim himself says of his own theory that there is little positive evidence to uphold it.

Mr. A. R. BRAILEY, B.A., on "The Causes of Recurrence, and Secondary Growths."

The question as to the causation of secondary deposits and recurrence with which I have to deal to-night is, I think, an extremely difficult one, firstly, as it depends entirely on what decision we arrive at as to the cause of the *primary* deposit, and secondly, owing to the very meagre literature which there is on this subject.

The question as to why with a primary deposit in one situation secondary deposits are found only in certain organs does not, I think, help us to arrive at any conclusion as to the primary cause of carcinoma as most theories will explain it. Thus if we accept the microbic theory, it is well known that certain parasites will only live in certain situations which are most favourable for their development, whilst if we accept the theory of direct cellular transmission tissue resistance at once comes to our aid. The same facts also largely explain why certain varieties of carcinoma, such as the true cancers give rise to numerous secondary deposits, whilst others, such as the epitheliomata only affect the neighbouring glands and extremely rarely the viscera, whilst

rodent ulcer practically never gives rise to secondary growths. On considering this vastly differing general malignancy of these varieties of carcinoma a striking analogy to tubercle is at once apparent. Thus rodent ulcer, which is a strictly local form of carcinoma, may be compared with lupus, a strictly local tuberculosis; epithelioma, with its glandular infection, with a cutaneous tubercular ulcer; and the true carcinomata with their numerous secondary deposits with disseminated or general tubercle.

Possibly rodent ulcer may be due to the same parasite that is the cause of the true carcinomata but to an attenuated variety, whilst epithelioma is due to one of somewhat greater activity. Senile tubercle and rodent ulcer also occur in older subjects than the more active forms of tubercle, such as phthisis, and the more malignant forms of cancer.

An argument which has been used against the microbic theory is the absence of secondary deposits in non-vascular tissues, such as the cornea and cartilage, and the great resistance offered by cartilage to invasion seen in the case of the great resistance of articular cartilage when the end of a long bone is the site of a myeloid sarcoma whereby the neighbouring joint is not involved. It is said that if the parasite is of such a size as not to be able to penetrate non-vascular tissues, such as cartilage and the cornea, it ought to be easily visible under the microscope, but if we regard the parasite as being only capable of living within the cells, this is easily explained. If we accept the cell theory we shall have to explain the occurrence or not of secondary deposits by one of the following:—

(1) That it is dependent upon tissue resistance, that is, that the resistance of mesoblastic tissues to surface epithelium is greater than that to internal or glandular epithelium, thus explaining the absence of internal secondary deposits in the case of epitheliomata and rodent ulcers.

(2) That it is dependent upon the size of the cells whereby some are of such magnitude as not even to be able to enter the efferent lymphatics as in rodent ulcers; others, though able to enter the lymphatics, are arrested in the filter formed by the fine reticulum of the neighbouring lymph glands, whilst others, such as those of the true carcinomata are so small that they are able to pass through the lymph glands and reach other situations. The relative sizes of the cells of an epithelioma and of certain carcinomata do not support this view; those of the latter being often larger than those of the former, but it must be remembered that it is the minimum magnitude of each cell when it is first formed, and not the size of the adult cell, which is of importance. Another point, however, which is in opposition to this view, that the question of secondary deposits depends upon the size of the cells, and which too is of surgical importance, is the fact that the efferent lymphatics from a carcinomatous deposit can often be demonstrated microscopically to be full of carcinomatous cells, and often clinically also in that variety of cancer known as "cancer en cuirasse," yet in the epitheliomata the tumour cells can never be demonstrated in the efferent lymphatics, hence in the cancers the importance of removing the primary growth and infected neighbouring glands in one piece as in Halstead's operation on the breast, whilst in epitheliomata the primary growth and the enlarged glands may be removed separately, as in the case of the tongue.

(3) The size of the lymphatics may determine the presence or not of secondary deposits; thus the superficial lymphatics may be smaller than the deep, and this might explain the "cancer en cuirasse," which, as far as I know, only occurs in the skin, where, the lymphatics being smaller, more cancer cells may be arrested.

That this is not the true explanation is evident when one considers how deeply a boring epithelioma will extend when numerous deep lymphatics must be involved.

Another factor which might be expected to influence the situation of secondary deposits, especially if the cancers are due to parasites, but which has not to my knowledge been recorded, is the formation of a secondary growth at some preceding site of irritation, whereby the vitality of the part is lowered. In infective diseases this is sometimes the case, as in the numerous pustules which form on a surface previously irritated, as by a blister in a case of variola. So that in a patient suffering from an epithelioma a secondary growth might be expected at the site of a chronic eczematous condition.

Recurrence.—The fact that a primary growth is almost invariably single has been made of great use by opponents to the microbic theory, yet if we consider other infective diseases, such as tubercle, which I have already compared with growth, how frequently is a tuberculous lesion single. What a vast majority of the tuberculous joints—hip, knee, etc.—are single; in fact, it would be quite the exception to see two joints affected primarily at the same time.

How identical are the operative results also; often after excision of a joint complete cure is effected, the patient never after developing tubercle at the previous site or elsewhere, whilst sometimes failure or recurrence occurs, followed perhaps by general tuberculosis or secondary deposits.

The President having declared the subject open for discussion—

Mr. BOWEN further criticised the parasitic theory by asking how the rapid fungation of tumours reaching the

surface was to be explained, since the parasite was said to be anærobic.

Mr. HERTZ remarked that the occurrence of growths in scars negatived Cohnheim's theory; also against the theory of irritation could be cited the numerous instances in which no irritation was present. The only solution was to regard cancer as infective, and the absence of reliable knowledge of any organism no more invalidated this conclusion than the non-discovery of the organisms in the case of measles and scarlet fever. Irritation and the presence of embryonic rests might determine the position of a growth.

Mr. BLACK supported the infective theory.

Mr. MOLLISON suggested that the parasite might be one which lodged in an intermediate base as in malaria, and that this might explain the fruitless result of attempts to cultivate it.

Mr. HOWARD in answer to Mr. Bowen said that the rapid growth of fungating cancers could be explained by supposing that the presence of an aerobic organism in addition to an anaerobic was favourable to the growth of the tumour, and instanced tetanus, in which such a double infection is necessary before virulence is developed.

Mr. M. de L. ROBINSON, in defence of the contention that the parasitic bodies are not cell-inclusions, laid stress on the fact that they stain differently to the cells.

Mr. ALLAN reviewed Plimmer's experiments, in which he succeeded in inoculating mice with growths, and said that it had been shown, however, that these animals are prone to die of such growths whether inoculated or not. He also referred to the paper of Cheatle, who drew attention to the frequency with which cancer occurs at points on the skin supplied with nerves from definite spinal segments, that is to say, in the centre of Head's areas.

Mr. R. THOMPSON pointed out that a combination of all three theories—irritative, embryonic, and infective—would be most likely nearer the truth than any one. It is by no means necessary that all Koch's postulates should be fulfilled before we accept the infective nature of cancer.

Mr. MANN said that the chemical relations of cancer had so far not been sufficiently investigated.

Mr. F. W. MORTON PALMER rejected the triple theory and proposed a choice of two double ones, in which infection and irritation, infection and an embryonic rest were the determining factors. He quoted the existence of growth occuring at the site of every vesicle after herpes zoster, and an instance of cancer occurring in the eczematous area produced by the X rays.

Mr. TRAIL then moved a vote of thanks to the gentlemen who opened the discussion, and this was seconded by Mr. STEVENSON, and carried with acclamation.

The Society adjourned at ten minutes past ten.

The next meeting of the Society is on Saturday, January 16th, in the Wills Library, at 8 o'clock, under the chairmanship of Mr. K. Black, and will be a clinical evening.

Berlin.

BERLIN is a very efficient city, without any charm. The Emperor has announced his intention of sparing no expense, to his subjects, to make it the finest capital in Europe. And that is precisely the impression it conveys. As regards the people, what first strikes a tourist is that the women all dress badly, and that the men have an elaborate manner, but no manners. In other possibly more important respects it is a good deal ahead of London. A man who breaks his leg in the street is not taken to hospital in a barrow. By means of numerous first-aid stations and effective telephones he is sure of getting a doctor and horsed ambulance on the spot in a few minutes. And the working man who falls ill has no anxiety at all. It is not left to his initiative to enrol himself as a Son of the Phœnix, or one of the Order of Comical Fellows. Before he receives his wages a small percentage is deducted by law for the Krankenkasse. When he needs it the Kasse pays him the doctor of his choice, provides for him free medicine, milk, or port, whichever is prescribed, and sends him to a convalescent home afterwards. If he is permanently unfit, he retires to a palace in a pine wood, with free skittles to divert his leisure, and stays there indefinitely. With all this the Kasse, an institution of Bismarck's, is at a loss how to spend its surplus.

These patients are catered for by a number of out-patient departments called Polykliniks, which are installed usually on one floor of a set of flats, and are each worked by a staff of doctors who divide the special departments between them. As the Kasse fees are less lavish than its other arrangements mo t of them try to take one or two pupils, seldom more than three, chiefly doctors from the country or abroad, who wish to refresh their practical knowledge or to learn the use of instruments such as the cystoscope or laryngoscope. They charge two or three pounds for a month's course, which consists of 1 to 2 hours three or four times a week. Some teach very well—even those who do not are at least an excellent means of learning German.

Lists of them are published, and twice a year, under the auspices of the University, they combine with other medical professors and lecturers to provide a month's instruction for practising doctors in every imaginable subject. During that month 134 different sets of lectures or clinics are offered, including "hygienic excursions" on Saturday afternoons. These intellectual debauches take place every March and October. They must be a real benefit for men in country practice, who want to learn how to deal with any special class of case. They get a course of a scope and duration which is possible for them, and at the same time they have a wide choice of other courses within the same dates. There would hardly be this supply if there were not a considerable demand, but as far as I know there is nothing on this scale in England.

A foreigner finds no difficulty in attending the clinics or operations of any of the great surgeons, who are very kind to strangers, however insignificant.

In Berlin one can live in what Germans consider comfort for four shillings a day. Certain seats in the Opera are reserved for students, and the music everywhere, as also the beer, is cheap and good. On the whole it is better to be a Londoner in Berlin than a Berliner in London.

OWEN RICHARDS.

Appointments.

House Appointments.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—

House-Physicians.—Messrs. G. E. Malcomson (Dr. Taylor); B. Glendining (Dr. Pitt).

House-Surgeons.—Messrs. Kenneth Black (Mr. Lucas); L. S. H. Glanville (Mr. Jacobson).

Assistant House-Physicians.—Messrs. H. Mann and B. H. Wedd.

Assistant House-Surgeons.—Messrs. N. Ivens Spriggs and J. Goss (Front Surgery); R. G. Anderson (Mr. Lane); P. A. Peall (Mr. Dunn); W. F. Box (Sir Alfred Fripp); F. H. Wallace (Mr. Steward).

Naval and Military.

Surgeon H. G. T. MAJOR, R.N., is appointed to the *President* for three months' study at a civil hospital.

Colonel W. E. SAUNDERS, C.B., is transferred from the Poona to the Meerut and Bundelkhund Districts, but will continue to officiate as Principal Medical Officer, Bombay Command, until relieved by Surgeon-General Gubbins.

From the Gazette's Special Pathologist.

NOTICES.

G. E. H., Ramsgate.—This sputum contained a moderate number of tubercle bacilli.

S. W., Middlesborough.—This sputum contained a moderate number of tubercle bacilli, most of which were arranged in clumps.

A., Chippenham Road.—This sputum contained only a trace of pus and no tubercle bacilli were found.

PATHOLOGIST.

Papers by Guy's Men.

An Effectual Means of Dealing with Chronic Obstruction of the Large Bowel resulting from the Adhesions which develop in consequence of Chronic Constipation. By W. Arbuthnot Lane, M.S. Lond., F.R.C.S.—*The Lancet*, January 2nd.

Sport.

Football Fixtures.

SATURDAY, JANUARY 16TH.
G.H.R.F.C. I., v. Rosslyn Park, away.
II., v. Surbiton "A," home.
III., v. Old Blackheathens, away.
G.H.A.F.C., I., v. Beckenham, home.
II., v. Beckenham II., away.

SATURDAY, JANUARY 23RD.
G.H.R.F.C., I., v. London Welsh, away.
II., v. Norwood, away.
III., v. Catford Bridge III, away.
G.H.A.F.C., I., v. Reigate Priory, away.
II., v. Carshalton Park, home.

WEDNESDAY, JANUARY 27TH.
G.H.R.F.C., III., v. King's College Eng. II., away.

SATURDAY, JANUARY 30TH.
G.H.R.F.C., I., v. R.I.E.C., home.
III., v. Blackheath School, away.
G.H.A.F.C., I., v. West Kent, away.
II., v. Central Technical College, home.

Rugby Football.

Guy's Hospital v. Catford.

This match was played at Honor Oak Park before a large and enthusiastic crowd. Guy's were without Morgan, McEvedy and Jones. Guy's kicked off and at once attacked, the ball coming well away from the scrum. Alcock made one of his pushes for the line, but could not manage to get over. He had another opportunity later but was pushed into touch. Saunders also only just failed to score. Several scrimmages about the half-way line followed, Catford having the better of the game for a time. A kick by the Catford centre three-quarter enabled Helder to obtain possession and score for them. Soon after the kick out, Helder scored again from a good rush. At half time Catford were two tries, Guy's nil. After the kick out our forwards pulled themselves together and played a much better game. They obtained the ball in the scrum, and rushing it down the field, Ward picked up, and with a good pass to Saunders, enabled the latter to score. O'Brien failed with the kick. After the kick out Catford were seen to some advantage, but Harrison, with a good kick, sent the ball back again. Guy's, by strong defence, were able to keep their line intact, Husbands putting in some good work. Right up to the end the home side maintained the upper hand. Five minutes from the end a good passing rush among all the backs enabled Burney to score. After the kick out, the Catford forwards made a determined rush, but were driven back. From a scrum in front of goal, the ball went to Harrison who kicked, and Burney following up gained the winning try for us just on time. A fast and exciting game ended with Guy's 3 tries, Catford 2 tries.

REMARKS.—Husbands, at back, was cool and always got his kick in. Harrison and O'Brien played well at three-quarter, while Burney on the wing showed that he was a dangerous player on the attack. The forwards in the second spell played very well, Saunders, Ward, Mullens and Earle being the best.

Association Football.

Guy's v. South Eastern College.

This annual match was played at Honor Oak Park on Saturday, Dec. 19th, and resulted in a win for Guy's by 6 goals to love.

The visitors kicked off with their backs to the Pavilion when Guy's at once began to press, and after about ten minutes' play Norton scored the first goal, and a second was added by Litchfield a few minutes later.

In the second half Guy's continued to show their superiority, and further goals were added by Messent, Weening, Norton and Litchfield.

Pavy Gymnasium.

Inter-Hospital Contest.

A deputation from Bart's., Thomas's, and the London, met in the Pavy Gymnasium on December 19th, 1903, in response to an invitation, sent out by our Secretary, to try and arrange for an Inter-Hospital Boxing, Fencing and Gymnasium Contest; a letter was also received from Middlesex Hospital expressing a wish to join. A working committee was formed consisting of three members from each hospital (Guys: Messrs. Morgan, Reader, and Minett), and the first meeting was held on January 11th, when it was decided to hold the contest on neutral ground, most probably either at the Polytechnic or German Gymnasium, the date to be fixed in February, after the 11th and as early as possible. It was agreed that each hospital should give an annual subscription of 21s., also that each hospital should subscribe about £3 towards a challenge cup. There is a boxing cup already in existence at the University College Hospital, which it was agreed to challenge also.

The contest, after much discussion, was arranged as follows:—Each hospital's team to consist of four men for boxing, two for single-sticks, two for foils, and two for gymnastics, making in all seven events—four boxing, one single-stick, one foiling, one gymnastic. The points counted in finals only to be—winner three points, loser two points.

The hospital winning the greatest number of points, in all seven events added together, was to hold the proposed new challenge cup. But the boxing cup is kept distinct, and goes to the hospital winning most points in boxing events only.

Our weakest point is our fencing at present, but it is evident that should our boxing men pull off all their four events, we shall not only bring home the boxing cup, but having won four out of the seven events are certain to win both. We, however, hope to win the gymnastics and foils also, and of course, if we can, to win the lot.

The team chosen is given below, but there may possibly be some alterations before the date, as one of the boxing men is over weight at present, but hopes to be able to squeeze under by the date.

BOXING TEAM. — Messrs. Jones (Heavy), Minett (Middle), Morgan (Light), and Russell (Feather). Reserves: Messrs. Earle or Tollhurst (Heavy), Greene, Carr, or Bookless (Middle), Parkins or Marshall (Light), Baker or Thomas (Feather).

GYMNASTICS.—Messrs. Dyson and Reader. Reserve: Mr. Helyar.

FOILS.—Messrs. Glover and Reynolds, R. J. Reserves: Messrs. Peal and Carter.

SINGLE STICKS.—Messrs. Oram and Carter. Reserves: Messrs. Costobadie and Reynolds, S. L. C.

The hospitals at present competing are St. Bart.'s, St. Thomas, London, and Guy's. Middlesex Hospital has not yet joined.

The Inter-Hospital Hon. Sec. is Mr. E. Burgess (London); Hon. Treasurer, E. P. Minett (Guy's), either of whom will be glad to acknowledge subscriptions towards the new cup to be competed for.

Calendar.

January, 1904.

Sat. 16.—Messrs. Golding-Bird and Dunn's take-in; Drs., P. A. S. Dyson and A. B. Cocker; Cl., A. M. Webber.
Physical Society's Meeting at 8 p.m., Clinical Meeting. President, Mr. K. Black.

Mon. 18.—Preliminary Scientific and Inter. M.B. Lond. Exams. begins.

Thur. 21.—Mr. Jacobson and Sir Alfred Fripp's take-in; Drs., E. W. Sheaf and E. C. Hughes; Cl., C. D. Pye-Smith.

Thur. 28.—Messrs. Symonds and Steward's take-in; Drs., R. O. Williams and T. Turner; Cl., P. P. Cole.

Sat. 30.—Physical Society's Meeting at 8 p.m., Paper by Mr. P. A. Peall on "The Present System of Treating Feacture."

Births.

COLLINGTON.—On 21st ult., at 28, Much Park, Coventry, the wife of F. A. Collington, M.R.C.S., of a son.

MOON.—On 29th ult., at 50, Green Street, Park Lane, W., the wife of R. O. Moon, M.D., of a daughter.

Marriage.

TELLING—AAGAARD.—On December 31st, at St. Matthew's Denmark Hill, S.E., by the Rev. Dr. Porte, Walter H. Maxwell Telling, M.D., B.S., M.R.C.P. Lond., eldest son of H. T. Telling, Esq., of Hill Lodge, Champion Hill, S.E., to Ingeborg Cathrine Marie, eldest daughter of Julius Aagaard, of Copenhagen, Denmark.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

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CONTENTS.

	PAGE.
Guy's and the Guardians	41–42
Passim	42–44
Henoch's Purpura. Clinical lecture by Dr. W. Hale White	44–50
Notes from Skin Outers...	50–51
Notices	52
Nursing News	53
Physical Society	53
Appointments	53
In Lighter Vein	54–55
Reviews	55–56
Bob Sawyer in 1823	56
A few Notes on Four Cases of Fibroid Complicating Pregnancy	57–58
Guy's Hospital	58–59
Sport	59–60

Guy's and the Guardians.

IN the small hours of the morning on the 28th of December last, a man suffering from stricture was brought to the Hospital, received treatment which afforded temporary relief, and, there being no bed available for his reception, was sent in a cab to St. George's Workhouse, with a recommendation for his admission into that Institution. This proper and considerate action on the part of the house-surgeon the Southwark Guardians chose to regard as a "scandal," and proceeded to make an unjust charge against the Hospital with such noise and violence as to deceive a large section of the press into accepting the charge as true and publishing it accordingly, with very harmful results to the cause of this great Charity.

Now with regard to this particular case, the course followed by the Hospital is adequately vindicated by the fact that all its surgical beds were full. The wards at Guy's are not constructed on the principle of a concertina, and the strict regulation of the Governors against the putting up of extra beds with all the attendant evils of overcrowding, is beyond criticism. There is nothing humane, or sensible in attempting to cure one evil by the creation of another, and a worse. Moreover, it may be remarked that the case in point was one with which the officials of the Workhouse, with the assistance of their Medical Officer, should have been perfectly capable of dealing, and it would appear, when they were put to it that they did do so. The Guardians, however, have stated that the matter is not to be allowed to rest here. Neither, we hope, is it the intention of the Governors of the Hospital that it should; and we take this opportunity of informing the public upon certain facts which the Southwark Guardians are pleased to ignore. That body apparently assumes that Guy's Hospital exists and is supported for the especial benefit of the Borough in in which it is situate. In this they are quite mistaken. Whether honest or not the assumption is false. But for the sake of argument, assume it to be true, and let us see how Guy's fulfils its obligations to Southwark. To begin with, the Hospital pays some £3,000 a year in local rates. Then we find that of the 8,000 and upwards of In-patients annually accommodated, two-fifths come from the localities immediately surrounding the Institution, Southwark sending a considerable proportion of these; that less than two-fifths come from the outer London area, and the remainder from the provinces. Of the 125,000 Out-patients annually attended, by far the larger proportion comes from Southwark and Bermondsey. Again, a regulation exists requiring the Poor Law Guardians to pay two shillings a day for any Poor Law case in the wards. That regulation has never yet been met by the Southwark authorities, although carefully observed by Country Unions. And, for all this, what does the Hospital get in return from Southwark, or even from South London? Of the £90,000 which it cost in ordinary and extraordinary expenditure to keep Guy's going in 1903, there was contributed from Southwark the sum of £277, and from South London, apart from Southwark, £1,203. Not content

with receiving so much, to which they have no particular claim, the Guardians ask for more, and, not receiving it, adopt that hectoring attitude towards the Hospital of which the case under consideration is only the latest example.

But, if the Guardians are beaten on their own ground, as they unquestionably are, by the force of concrete facts, they are yet more hopelessly astray when the case is judged, as it should be judged, on the principle. May we be excused for reminding the Guardians, or informing them, if they are unacquainted with it, of the existence, intent, and provisions of the statute under which they hold sway. So long ago as the year 1601 the legislature of this realm adopted the principle that no necessitous person was to suffer want either in hunger or sickness, and proceeded to enact a measure, still in force, known as The Act of Elizabeth, and constituted an Authority charged with the duty of giving effect to the measure. That Authority in Southwark is not Guy's Hospital but the Guardians of the Poor, and the existence of the Hospital does not relieve them from their own legal responsibility. If the arrangements at St. George's Workhouse are so bad as not to enable the Guardians to deal with the sick cases which properly come within their province, those arrangements need altering, and we make the friendly suggestion that they should establish a reception station at the Workhouse where such cases can be retained until it is possible to safely transfer them to the Infirmary at Champion Hill. At any rate it should be understood that Guy's Hospital will continue to send to the Workhouse cases which the Hospital cannot accommodate and which need shelter and medical attention, and if the Guardians neglect to properly deal with these cases it will rest with the Hospital to refer their dereliction of duty to the Local Government Board.

Let there be no mistake in the public mind as to the merits of this case. It is the Guardians who are on trial, and not the Hospital. Guy's Hospital, a voluntary institution, is doing its work with efficiency and intelligence, and to the utmost limits of its resources. Perhaps, upon reflection, the Southwark Guardians may find it difficult, notwithstanding their control of the public purse, to say the same of themselves.

Passim.

AS a general rule with most of these sensational newspaper attacks on any of the great hospitals, the wisest course is to ignore them altogether, for what in reality constitutes a convincing and satisfactory explanation from the medical point of view, carries no weight with the average layman, who views things from the sentimental standpoint alone, and either cannot or will not understand that system and rules are as vital to a hospital's efficient working as to that of any institution. But there are certain aspects of the late "scandal" so-called, that deserve perhaps special attention. To begin with, it is a little surprising that so reputable and influential a newspaper as the *St. James's Gazette* should accept the evidence of the Southwark Board of Guardians alone as constituting a complete case against Guy's Hospital, for while those of the leading newspapers who attached any credence to the Guardians' story took the precaution to enquire also as to the facts from the Superintendent of the accused hospital, this journal alone, in company of course with the enterprising gutter press, rushed into print and heralded their mis-statement in staring type on their placards. Such a course of action may appeal to the commercial mind but it is scarcely worthy of a respectable paper. It is to be hoped that this is not a sample of the care generally taken by the *St. James's Gazette* in elucidating the truth from a tissue of lies and misrepresentation.

THE *Daily Telegraph*, the careful enquiries of whose representative resulted in a well-balanced article exonerating the hospital authorities from all blame, referred to a mistaken feeling that exists "that Guy's as a general hospital of high reputation draws into Southwark patients from far and wide, and . . . . has no beds for poor cases of no special interest to the student." Now this last is a fair sample of the style of criticism one expects from people of a certain class of mind, and without appearing to pose as martyrs in the cause of humanity, it might be as well to protest once again that such opinions should ever be entertained, and much more

expressed. No one would pretend for one moment that this hospital's work is carried on by philanthropists, a merciful providence having ordained that hard and continuous work shall effectively prevent any attempt on the part of the worker at offering a motive for the same. But what is laid claim to is the fact that this community, to a man, is at least as much inspired by the common sentiments of humanity as a Poor Law Guardian, although it may not be too proud of its common kinship with the latter.

THE whole absurd business has fizzled out like a damp squib, thanks to the dignified attitude of the House Committee and the commonsense of such papers as the *Daily Telegraph* and the *Daily News*. But we are far from anticipating a cessation of hostilities on the part of gentlemen, whose zeal for reform is only exceeded by their incapacity to perceive where reform is superfluous. As Mr. Thomas Cooksey remarked—or was it Canon Horsley?—"It was not the first or the second or the third time that complaints had been made in connection with Guy's Hospital." It would have been more accurate had he said "not the hundred and first," and it is certain that these complaints will continue so long as so many newspapers remain unregenerate. The journalist's answer doubtless is that "One must live"—and to that we would reply with Voltaire, "We don't see the necessity."

THE Nurses' Choral Society and Students' Glee Club will hold their second concert this session in the Court Room, on February 16th. One of the reasons given for this choice of a comparatively early date is that Lent falls early this year, and that in itself is of course a sufficient explanation. The programme on this occasion is to be varied, no big orchestral work having been undertaken, and we have no doubt that the entertainment will prove as excellent on this as on all previous occasions. No seats will be reserved, and the tickets, price half-a-crown, are to be obtained from the Matron, Sister Lazarus, or from the indefatigable honorary secretary, Mr. Felton. It is to be hoped that as many as possible will avail themselves of this opportunity of listening to a good concert, that the Court Room may be well filled, thereby giving an additional fillip to the musical talent of the Hospital.

MANY are the vagaries of the London University, as we have before pointed out in our columns, and now there is yet another curious flaw in the system which has recently presented itself. Candidates for the London M.D. are compelled to have held some hospital medical appointment for six months before they are eligible for examination. This regulation is of course natural enough, but what we altogether fail to understand is why the appointment of A.H.S. in the Front Surgery of Guy's Hospital cannot be considered by the University authorities as a medical appointment under their regulations. The post of A.H.S. in the Front is essentially a medical appointment as anybody with a knowledge of the facts must admit; the numbers go to show that as many as three thousand medical cases is a fair average figure for the three months' office. Surely this is an adequate enough experience to suit the demands of the University's regulations, constituting as in does a severe test of ability in more ways than one, together with no small burden of responsibility.

WHEN we consider these facts we are led to believe that it is purely the name of the appointment that has led to a misunderstanding as to its nature. Perhaps the title of Medical Officer or Receiving Officer would appeal more to that uncertain quantity, the official imagination. Certainly it will not be worth the while of the average London man to attempt the M.D. if he has to hold the posts, first of Clinical, second of A.H.S., and finally of A.H.P. in addition, before he is an eligible candidate, seeing that this would mean nine months' work, while the University only requires six months.

IN the midst of all these "alarms and excursions" it is pleasing to note that some of our erstwhile adversaries would seem to have buried the hatchet. Actions speak louder than words

and all will congratulate Mr. Stephen Coleridge on the generosity and freedom from rancour which prompted his recent subscription of one guinea to many of the London Hospitals. We hope that his name will figure boldly among the various lists of subscribers that all may see the significance of the action, and that many of the supporters of the Anti-vivisection Society, of which he is so energetic a Secretary, may see their way towords following in his footsteps.

THE Debating Society, which for some reason unknown has been suffering a temporary eclipse, holds its next meeting on Saturday, February 6th. The subject for discussion is to be "Marriage as a bar to Success," and this should prove a most successful debate seeing that the subject is comparatively abstract and well within the scope of the most theoretical. During the last few months the Society has lost, one by one, several of its most able speakers, and it is to be hoped that junior men will make a special effort to be present and to take part in the debate. It is to these latter that the Society looks in the very near future for its very existence.

THE Annual Dinner of Guy's Hospital Officers and Servants is to be held on Monday, Feb. 8th, at the Bridge House Hotel. The Treasurer will take the chair at this dinner.

THE commencement of the year has seen many changes in the Staff of the Hospital, and on the Dental side these are somewhat extensive. To begin with, Dr. Eason has succeeded to the post of Dean of the Hospital, which was left vacant by the resignation of Dr. Fawcett. Mr. Newland Pedley having resigned the lecturership in Dental Surgery, Mr. Wynn Rouw will in future lecture on the latter subject, coming on also as a full surgeon owing to the resignation of Mr. Badcock. Mr. Parfitt has been appointed lecturer in Operative Dental Surgery, while Mr. Payne comes on as Assistant Dental Surgeon and Lecturer in Dental Mechanics.

Henoch's Purpura.

CLINICAL LECTURE BY DR. W. HALE WHITE.

October 24th, 1903.

GENTLEMEN,—We are going to take to-day the cases of three children who have had purpura. The first is a girl, æt. 13, who was admitted on September 10th, two years ago. Her family history was comparatively unimportant, the only point being that several of her uncles are said to have had rheumatic fever. Her own history also is unimportant, and we can come at once to the present illness. The report says that on April 7th and 8th, she was complaining much of pains in the legs, but she got up and went about without difficulty. On April 14th, she was seized with pains in the abdomen and vomiting. Dr. T. A. I. Howell was called in on April 16th, and he kept her in bed for a few days. The sickness passed off, and after this she felt quite well. About April 21st, her mother found, when undressing her, a rash on the legs. It was exactly similar to the purpuric rash she had when she was in the hospital. A few days after this rash she had a mild attack of fever, thought by Dr. Howell to be rheumatic fever. He kept her in bed until the beginning of August. During her stay in bed she had many attacks of severe sickness and pain in the stomach, each of which lasted about three days. During the attacks the pain was very severe, so that her mother had to rub her back and abdomen for hours together, and the child writhed in pain, also during an attack she was constantly vomiting, bringing up all food. Her breath was offensive. The pain was all over the stomach and round to the back. While an attack lasted the motions were very dark, almost black, and on at least two or three occasions there was undoubtedly blood in them. The mother showed them to Dr. Howell, and he told her that they contained blood. The pain occurred in paroxysms, lasting two or three hours, followed by an interval of freedom from pain for two or three hours, the whole attack lasting about three days. On the third day the pains suddenly left her. Then there was an interval of three or four days during which she was quite well; and then again an attack would come. The severity of the attacks slowly diminished, and by the end of June they disappeared. She had another attack at the beginning of September. This was much shorter. Since April 21st the rash has never really left her, or at least only for a few days. It consisted of dark hæmorrhagic

spots, which gradually faded like a bruise and left a stain. A fresh crop would come out before the brown stain of the old ones had gone. The mother thinks a fresh crop came out once every three weeks. The rash was confined to the thighs and legs, except that on one occasion it was slightly on the elbow. During her illness the gums often bled, but she had been liable to bleeding of the gums. Blood was first noticed in the urine when the illness began in April, and at times the urine has been quite red. Although its depth of colour varied much on different days, there was always blood in it till admission. Once there was a little blood in the vomit. I can quickly tell you how she was when she was here under observation. She had purpuric spots all over her, especially on the legs. She once or twice had some more of the severe attacks of gastric pain, and she passed a quantity of blood in her urine. So the summary of the case is, periodic attacks of abdominal pain, diarrhœa and vomiting; purpura, melæna, hæmaturia.

The next case is a boy, now in John ward, who is 14½ years old. He came in for hæmaturia and purpura. We are told that about March, 1902, he had great pain in the lower part of his stomach. Associated with this he had severe pains and swellings in the ankles, so that he could not walk. On October 3rd this year he found his legs and arms were all covered with red spots. The next day both knees and both ankles were swelled and painful. All that day and the next he vomited a greenish slime, and at the same time he passed a black motion. On October 6th he went to bed, and had some medicine to open his bowels, which resulted in six coal-black liquid motions, and there were pains across the pit of the stomach. These pains, with diarrhœa and vomiting, continued, but gradually grew less up to October 10th, when they stopped. The pains and swellings in the joints had also subsided by this time. Then, until October 14th, he was well. On Wednesday evening, October 14th, another crop of spots came out. On October 15th, he was in pain across the lower part of the chest; he vomited, and his nose bled. He had five motions that day. October 16th he vomited a clot of blood, and passed a quantity of blood per rectum. He only took a little milk by the mouth, and vomited that up. During the last attack the joints did not swell, and were not painful. The water varied from a clear colour to that of coffee. When he came in he had a temperature of 99·4°. He is an anæmic-looking boy, and was found to have several patches of purpura about him, especially on the extensor surfaces of both legs. The spots were small, none being larger than a threepenny piece; there were a few on the arms. There were one or two bruise-like marks about him, one being especially evident on the inside of the right thigh. There was no discoloration of joints, and none were painful. The urine was very concentrated, contained a good deal of urates, and a fair amount of blood. There was no hæmic bruit. The circulatory, respiratory, and nervous systems were normal. There were no hæmorrhages in the eyes. The blood examination showed nothing more than anæmia which would correspond with this loss of blood. He gradually got better, and is better now. Before I pass on to the third case I want to draw your attention to the fact that the boy resembles the girl. He has sudden attacks of abdominal pain, associated with diarrhœa and vomiting, and has purpura occurring in crops, and also melæna and hæmaturia.

The third case is that of a child, whose viscera are here. She was two years five months old, and came in on the 10th of this month for a purpuric rash, a nasal discharge, and general œdema. The history of her family and her previous history were unimportant. The present illness began three weeks ago with pain in the head, puffiness of the right eye, and a foul discharge from the right ear. Two days later the left ear discharged, and the feet and legs swelled. The discharge from the ears stopped in three days, the œdema went, and she had a week of good health. A week ago she had a discharge from the nose, and was drowsy. On October 8th the feet and legs again began to swell, hæmorrhage occurred from the mouth, and the nasal discharge was more profuse. On October 9th she had a rash, similar to that which she had on admission, all over her, and this was chiefly a purpuric rash. On admission the extremities were seen to be swollen, and she was slightly rickety; she had a bilateral nasal discharge, with excoriations on the upper lip below the nostrils. She had general œdema of eyelids, feet, legs and hands, and it was most marked on the hands, which were shiny. She had a purpuric rash all over her, small purple dark red spots, all apparently the same age. They were scattered about in many places, especially on the head and trunk. Between the thighs there was some erythema intertrigo, and on the outer side of the thighs pale erythematous scaly patches. The child was very cold, the pulse very rapid and hardly perceptible. She seemed collapsed and drowsy, there were a few râles at the bases of the lungs, but

no murmur could be heard over the heart. The urine was healthy; there were no Klebs-Lœffler bacilli in a swab taken from the throat. The white cells were 7,000. She was given some diphtheria antitoxin and strychnine, because it was suggested when she came in that she had nasal diphtheria with purpura. On Oct. 11th there was a trace of blood in the urine. A blood film was normal. On October 12th the temperature was 102°, and she had signs of pneumonia in the middle and lower part of the left lung, and at the right apex in front. A fresh crop of purpura was seen below the knee and over the trunk. The urine contained blood. On October 13th she was much worse in all respects, more purpura, more hæmaturia, and she died after her temperature had gone up to 104°. Here are the viscera. They showed admirably at the *post-mortem*—and to some extent they show now—the occurrence of hæmorrhages. These can be seen in that portion of lungs where there is pneumonia corresponding to the physical signs observed during life. And at the post-mortem it was quite easy to see that there were large hæmorrhages into the spleen. You can see clearly even now that there were hæmorrhages into the connective tissue around the pancreas, and submucous hæmorrhages into the stomach and large intestine, Peyer's patches being specially affected. The liver was remarkably fatty, you can still see that it is so. It was so fatty that a thin slice floated on water. The kidneys do not show anything abnormal; the brain was healthy, there were no subperiosteal hæmorrhages over the tibia. The ears were normal, and the antrum on both sides was normal, but the nasal mucous membrane was inflamed. Blood taken from the ear during life showed some streptococci, and that taken from the heart after death showed some streptococci, also bacilli coli communis.

You will notice that the common point about these three cases is, that they all had purpura. A list has been published by Stephen Mackenzie giving a classification of 200 cases of purpura at the London Hospital. It is not at all likely that our cases will differ very much from those of a hospital just across the river, so I thought the best way to tackle the subject would be to give you his list and see how far our cases would fit into it.

The list, slightly modified, is as follows:—

Rheumatism	61
Doubtful	10
Bright's Disease	9
Heart Disease	8
Anæmia	6
Scurvy	6
Privation	5
Tuberculosis	4
Malignant Endocarditis ...	2
Congenital Syphilis ...	2
Alcohol	2
Injuries	2
Convalescence	2
Malaria	1
Rickets	1
Whooping Cough	1
Cirrhosis	1
Hæmophilia	1
Varicose Veins	1
Peripheral Neuritis ...	1
Henoch's Purpura	0
Multiple Sarcomata ...	0
Specific Fevers	0
Unexplained	68

Now, you will notice that our three patients to-day were all children, so for our purposes the list must be modified a little. For instance, in this list there are no cases of purpura due to specific fevers. But purpura is common in specific fevers which are common in children, but such cases are not often admitted into a large general hospital such as Guy's or the London. It occurs in typhus, and variola, and scarlet fever, and to a less degree in measles, vaccinia, and diphtheria—it was suggested that our third case was purpura due to diphtheria—and it occurs in epidemic meningitis. Another point in which the list wants correction is, that in a general hospital a fair proportion of children are not admitted, because of the existence of children's hospitals. Dr. Mackenzie has got in his list as causes in a few cases, privation, tubercle, and anæmia, yet in children any severe disease which causes anæmia will cause purpura. For example, wasting diseases of children, as abdominal tubercle, or gastro-intestinal inflammation or summer diarrhœa frequently cause purpura, and the above list underrates the frequency of such purpura. It is to that the name purpura simplex is given. It is usually slight, it is never accompanied by hæmorrhage from the mucous membranes, and although it means that the prognosis is bad the purpura passes away if the child gets well. There is a rare form of purpura described in children, of which I have not seen a case—purpura fulminans, and that is not represented in these two hundred cases. It is a very severe purpura, and in a few hours there are bleeding vesicles on the skin, albuminuria, cerebral symptons, and the child dies. We know practically nothing about the disease.

One thing I cannot quite understand about the list is, that you see there is no case of purpura mentioned in association with jaundice. It is common knowledge that purpura may be associated with jaundice. People with jaundice, as surgeons know, are liable to bleed very much. Some of you may remember a woman who came under me in Mary ward within the past twelve months, and she had several bruise-like hæmorrhages under her skin, she was deeply jaundiced, and she came in for a diagnosis as to the cause of the jaundice. She had not been in the hospital twenty-four hours before she began to bleed furiously from the vagina. The obstetric department could not stop the bleeding, and she actually bled to death from the bleeding which was associated with her jaundice. There was no malignant disease in the uterus, with secondary deposits in the liver. Then this list does not contain what is the commonest cause of purpura, and that is flea bites. I mention that because many beginners confuse the purpura due to fleas with serious illness.

As the list shows rheumatism to be by far the most common of the known causes of purpura, we must, when we see patients with purpura, try to make out whether they have purpura because they are rheumatic. It is necessary to get into your minds clearly that it is not by any means necessary for the purpura to be associated with rheumatic fever. If any of you, for instance, have had rheumatic fever and you subsequently at any time get purpura, I think it would be fair to assume, unless there is evidence to the contrary, that it is rheumatic purpura. We considered that in our cases, but we quickly decided that not one of our three children had rheumatic purpura. The reasons we so concluded were as follows:—Although rheumatic manifestations, such as "growing pains," pericarditis, and so forth, are common in children, it is a strange fact that rheumatic purpura is almost unknown in children under puberty. Somewhere about 30 is the most frequent age for you to meet with rheumatic purpura, and it has quite a definite history and distribution. If you get a typical case the patient will tell you that one evening he felt a pain in his legs—a swelling kind of pain; that he looked to see what was the matter, and he saw symmetrical bright red patches over the front of each tibia. He will say, perhaps, that the ankles swelled a little and the legs were a trifle stiff, but they were better next morning. But on the second evening the same thing recurred, and then the rash was more marked. He then comes to the hospital, and a dull coloured erythema is seen. That is the typical erythema nodosum, with some swelling, and in that, a livid patch of purpura has occurred. In severe cases the purpura occurs in other parts of the body. It is characteristic of rheumatic purpura that it is so largely a disease of the lower extremities; it is rather rare on the upper extremities, and decidedly rare on the trunk. Another thing is, it is one of the rarest occurrences in medicine to meet a case of rheumatic purpura associated with bleeding from the mucous membranes, and you will have noticed that each of our children bled from some mucous membrane. Also, there are no internal hæmorrhages in rheumatic purpura. Our cases vomited blood, and they passed blood in the urine; while in the one which died, hæmorrhages were found in the lung and connective tissue. Lastly, none of our children showed any evidence of rheumatism, and there was no affection of the heart pointing to it. I have found some confusion among students about rheumatic purpura, and I think it will be well to put it right before we leave it. It is confused because it is also called peliosis rheumatica. The muddle is complicated, for the cases originally described by Schönlein, seventy years ago, as peliosis rheumatica, were in reality examples of erythema papulatum.

It was also clear that none of our three patients had Bright's disease, and in passing I would remind you that it is very necessary to remember this liability of people with Bright's disease to bleed. It is notorious that they often die from cerebral hæmorrhage, but they may also bleed in less frequent sites than the brain. I sometimes tell the tale of a man whose Bright's disease was recognised because of a hæmatoma in his ear. I have often seen people who were thought to have disease of the genito-urinary tract because they bled there, but were really suffering from Bright's disease. A well-known physician first knew he had Bright's disease—which killed him—because he coughed up blood. Sufferers from Bright's disease also frequently bleed into their retina. Always be on the lookout for Bright's disease in people who have purpura or internal hæmorrhage. Adults in whom anæmia is the cause of purpura are mostly sufferers from pernicious anæmia, and our patients had not got that. Then we pass to scurvy. Obviously they had not got ordinary scurvy—or rather it is now becoming extraordinary scurvy, for many of you may never see the disease at all. But I happen to have seen a good deal of it, because I was for some time in the *Dreadnought*. No case of purpura is due to scurvy unless the gums are spongy. Occasionally house-physicians ask me to see a severe case of

purpura or hæmaturia, thinking they have got a case of scurvy. You can set the question right at once by the state of the gums; sometimes in scurvy they are so swollen as to actually hide the teeth, as I have seen. The question was raised whether our patients were suffering from what is called scurvy rickets, or infantile scurvy, which is an extremely interesting disease, in which hæmorrhage takes place under the periosteum of the bones, especially those of the lower extremities, and particularly the tibia. But that is quite a characteristic disease, which occurs in children at the time that they are being artificially fed, so that it occurs certainly before the eighteenth month of life; therefore none of these children could have had it. The characteristic sign is that the child suffers great pain in the legs, and so painful is the condition that the child will not move, and resents being examined or touched. It is pathognomonic of the disease to be able to go to a cot and see a child under eighteen months throw its arms about while its legs lie immobile, especially if it cries when you go near it, from dread that you may touch the painful legs. When you come to feel the legs you find there is a swelling under the periosteum. There is no doubt that sterilized food will lead to scurvy rickets. No entirely breast-fed or fresh cow's-milk fed children ever get scurvy rickets.

In none of our children was there reason to suppose that the trouble was due to privation, or tuberculosis, or malignant endocarditis. But there is another matter: whenever you see a case of purpura you should think whether it is due to drugs. For practical purposes the only drug which will cause purpura is iodide of potassium. Chlorate of potash will do it too, but it is never now given in sufficient doses. Thirty years ago many children were killed with chlorate of potash, the notion being that it would yield up its oxygen in the tissues, and in some obscure way it was hoped that the oxygen would save the child from severe fevers. Many cases got purpura, hæmoglobinuria and other signs of chlorate of potash poisoning. Iodide of potassium may cause erythema, which if severe may be purpuric. A rash due to this drug often closely resembles some forms of acne, perhaps because it is excreted by the sebaceous glands. We were able to say that our cases were not examples of a drug rash nor of congenital syphilis, nor whooping cough. And it is because Dr. Mackenzie's figures are taken from a general hospital, where so few children are taken in that the number of whooping cough cases are so few. Children with whooping cough frequently get purpura, and bearing in mind the fearful paroxysms of the cough, the obvious explanation seems to be the correct one, that during the coughing the blood pressure is raised, and that leads to extravasations under the skin. Next we come to cirrhosis, and that did not enter into our cases. But I am constantly pointing out to you the importance of remembering it as a cause of purpura. It was suggested that they might be suffering from hæmophilia, but the essential of that is not only that there shall be spontaneous hæmorrhages, but that the patient shall very easily bleed as the result of injury. Sufferers from hæmophilia frequently bleed into their joints. May I beg you to bear that in mind? because joints have been opened and the patient killed because the doctor has forgotten that one of the great symptoms of hæmophilia is bleeding into the joints.

You will say this is getting depressing, for we have not yet explained the purpura in our cases and none of the remaining causes seem to fit them; but I think the first two were examples of that rare disease Henoch's purpura. It occurs in children who are under the age of 16, and, as Henoch himself said, not infants. One great feature is, that the child is liable to attacks of severe abdominal pain, diarrhœa and vomiting; and the other is, that the child is liable to purpura. And the curious part about each of these is, that they come and go in paroxysms, as was the case with the first two children whose reports I read to you, and in the intervals between the paroxysms the child is quite well. Then, not long afterwards, the child is again seized with abdominal pain, severe diarrhœa, vomiting and purpura. To that description may be added one or two minor things. These patients frequently complain of pain about the joints, but it is not as severe as that of rheumatic fever, and the mother tells you that the joints are swollen. But the swelling is slight, and that must have been so in our cases, because by the time the children came under observation the joint swelling could not be seen in either. Another point is, that in a severe case there is usually a slight rise of temperature. In the second of our cases the temperature was 99·4°. Occasionally, but not very commonly, erythema has been described in the disease, but, as far as I remember, none of Henoch's original cases had any erythema. I think it is necessary you should remember that there is no particular order in which these symptoms may occur, because some writers have tried to make out that the abdominal symptoms invariably precede the purpura. That is no so. In order to get a good

conception of the disease one should enlarge upon the fact that this purpura is in many cases accompanied by internal bleedings, for, as in both our cases, the vomit may contain blood, so may the motions, and, much rarer, as in both our cases, the urine may contain blood. Inasmuch as the disease is rarely fatal, you could hardly expect to detect internal hæmorrhage elsewhere than in the vomit, the motions, and the urine. There is no evidence that treatment has any benefit on the disease; all you can say is that the child appears to grow out of it, after having repeated attacks of the abdominal symptoms, the purpura and the discharges of blood. But I think I can impress the points upon you better by giving you an account of some of Henoch's actual cases. I will read you one. It will be of interest to hear the very first case that attracted his attention to the disease. He says: "A strong boy of 15 years had an attack of gastro-duodenal catarrh, with slight jaundice, resulting from indigestion. A few days later there was pain in the joints without swelling. A day or two later an extensive eruption of purpura on the thighs, followed soon by violent colic, vomiting, and black stools. The pain within the belly was sometimes so severe as to keep the child from sleeping. The region of the transverse colon was distended and tender. There was slight fever, but never above 101·7°. After five days these symptoms disappeared, but within the next three weeks a relapse occurred, with exactly the same symptoms. Convalescence after one week. Within the next few weeks three other relapses, always accompanied by bloody motions. There were five such attacks within seven weeks, and finally complete recovery. The jaundice in this case was much too slight to have been the cause of the purpura.

The second case of Henoch's which I marked as being a very good one is this: "The fourth case was that of a girl, æt. 11, who, in the summer of 1872, had rheumatic pains in both ankles and right hip." And you will notice that, as in our cases, they seemed to precede by a long while the more marked manifestations of the disease. "In July, 1873, there was again pain in the wrist and ankles, but no swelling. This was immediately followed by purpura on the lower limbs. There was moderate fever, loss of appetite, vomiting, colic with solid motions containing large quantities of blood. The urine was normal. In the course of five weeks three such attacks took place, at intervals of eight or nine days." The child ultimately got quite well. Henoch does not make much of the association with rheumatism. You will notice that in regard to our first case there was rheumatic fever in the family, although not in the patient; and in both our cases there is no direct evidence of any rheumatism except that the joint swellings and pains which the children had were ascribed to it. Whether the disease bears any relation to rheumatism I do not know, nor are authorities settled in the matter. But at any rate, as I have pointed out to you, the arthritic symptoms are slight, and the disease is different from rheumatic fever, because it is never associated with endocarditis, and rheumatic fever is not associated with colic and internal hæmorrhages.

Here is an English case which has been published by Dr. Orr, in the *Practitioner*, and which I thought would interest you. This girl was 14. A year prior to her illness she had a slight attack of purpura, but recovered. A year later her pulse rose to 106, her temperature to 99·6°, and petechiæ occurred about the wrists and ankles, and there were patches on the extensor aspects of the legs. A fortnight later the note is, "The clinical phenomena have become absolutely periodic. The child gets periodic attacks of purpura, with slight swelling and pain in the wrists and ankles." And then it is noticed that the tongue has a peculiar look, having on it oval patches of whitish fur. And now occurs for the first time—sometime after the purpura—considerable abdominal pain, with vomiting of bilious matter and mucus, attended with nausea and depression of spirits. This is a very interesting case, for the disease lasted a long while, and the attacks occurred regularly, one every week.

We have now to consider our third case, which we did not think to be Henoch's purpura, and it obviously is not, because the child is too young. Furthermore, it died, which the subjects of Henoch's purpura seldom do. It had no abdominal crises, vomiting, passage of blood, and so forth, and it had a very high temperature, and nasal discharge. So this case comes among the unexplained in the list, but we will see if we cannot get it out of that category. Some of the unexplained are examples of a disease which we know very little about, called purpura hæmorrhagica. That is a bad name, because all purpura is hæmorrhagic. It was described by a German physician named Werlhoff as long ago as 1775, and was called "morbus maculosus Werlhoff." It usually occurs in males, and there is considerable purpura, especially under the skin of the penis and scrotum. Patients bleed from the nose, mouth, gums, and the skin may slough; they also get hæmorrhages into the retina. Here is a typical case of a man admitted into

Clinical ward under me not long ago. Four days before admission he had hæmorrhage into the tongue, two days later, hæmorrhage into the gums, lips, and mouth generally, and, one day before admission, into the skin. On admission he was covered all over with purpuric patches; the gums, mouth and tongue all had hæmorrhages in them; there was a decomposing blood clot in his mouth, and his temperature was 96°. The eyes were healthy. He died suddenly during the night. The sudden death suggested that he had cerebral hæmorrhage, and that was found so at the post-mortem. Also, in addition to the hæmorrhages I have mentioned, he had them in the trachea, pericardium, cardiac muscle, under the mucous membrane of the œsophagus, stomach, intestines, enormous hæmorrhages under that of the bladder, into the kidneys, and the brain. That is a typical case of the disease which we call purpura hæmorrhagica. It is possible this child may have been an example of that, and that it got pneumonia, bleeding took place into the pneumonia area, and so the child died. But for my part I do not think that is so. I believe in our third case the purpura, and all the internal hæmorrhages, were due to the fact that the child was suffering from very severe septic disease. It had an extremely foul, acrid discharge from its nose, which was enough to set up septic trouble. The report said that streptococci and bacilli coli communis were found in the blood. Moreover, very much against the notion of purpura hæmorrhagica is this state of the liver, which is so fatty that it floats on water, for the loss of blood alone was not enough to cause fatty liver, but associated with some severe septic condition it might well have done so. I think the correct explanation of the case is that the child was suffering from septic infection, so severe that it got many hæmorrhages, just as they frequently occur in specific fevers; hæmorrhages into the skin, the spleen, the tissue round about the pancreas; that pneumonia then developed, and hæmorrhages occurred into the pneumonic lung and the pneumonia killed the child.

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Wednesday, February 3rd and 10th, 1.30 p.m., Clinical Surgery, by Mr. Jacobson.

Saturday, January 30th, February 6th and 13th, 1 p.m., Clinical Medicine, by Dr. G. Newton Pitt.

Monday, February 1st, 1.15 p.m., Lecture by Mr. Targett.

Monday, February 8th, 1.15 p.m., Lecture by Mr. Brailey.

Notes from Skin Outers.

(BY PERMISSION.)

Alopecia.

"It's me 'ead, Sir."

And this was perfectly obvious, for his cranium was as smooth as the proverbial billiard ball.

The patient was an undersized lad aged 15. Sir Cooper Perry pointed out that this was a case of *alopecia universalis*, no hair on scalp, no eyebrows, no eyelashes, and very little growth on arms. That the cause is probably a tropho-neurosis (witness reported cases associated with shock and the neurotic diathesis and also the sometimes very sudden onset). In the present case the hair took six months to come out, and the condition has lasted a year; *no ascertainable cause.*

In these cases the prognosis must be guarded; the thinner and the more adherent the skin to subjacent tissues, the worse it is. Even if cured recurrence may occur.

Remember also that besides the hairy parts, the nails on the fingers and toes may be affected or even shed altogether.

Points then to note in the present case are:—

(1) Extent of disease.
(2) *Age of patient.*
(3) Sex—it is generally stated to be more common in males.
(4) Whiteness of affected skin (arguing atrophy).
(5) Absence of even downy hairs.
(6) *Absence of definite cause.*

The treatment adopted was the application of Linimentum Terebinthinæ Aceticum to be rubbed into head, arms and legs.

During the same afternoon that the above patient came up for advice, several cases of *alopecia areata* were seen. The ages of the patients were various, but none of them old; most of them were males; incidentally it was pointed out that beyond the age of 15 it was practically unnecessary to consider tinea tarsinorus as a disease to be excluded.

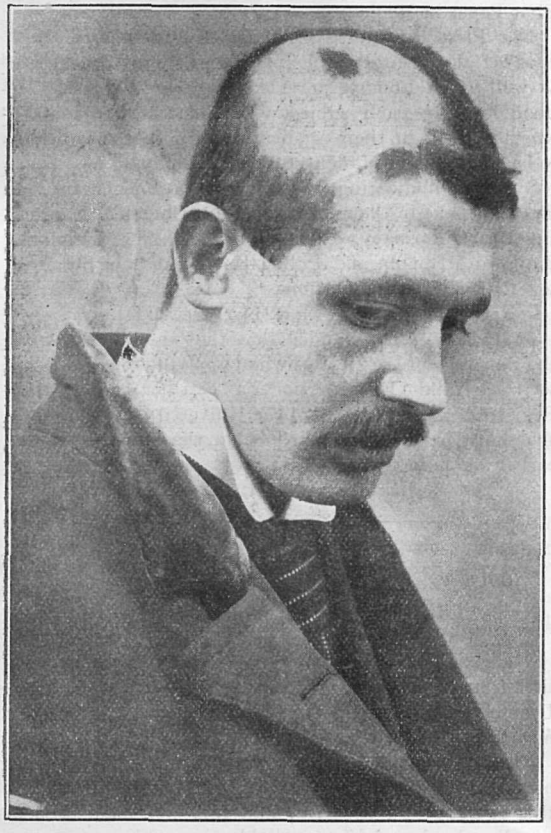
The following points were laid stress on:—

(1) The very localised, circular, bald patches.
(2) The whiteness of the skin.
(3) Absence of scurf and broken hairs as a predominant feature (as in ringworm).
(4) The occasional presence of "note of exclamation" (!) hairs around the margins of the patches. These hairs are white at the roots, dark at the periphery, short, and easily pulled out.

There are two theories as to its cause. Is it a neurosis? Is it parasitic? Neither has been definitely proved.

On another afternoon a variety of *alopecia areata* was pointed out by Sir Cooper as supporting the parasitic theory: the patient was a young man aged 26, the right

half of whose scalp was almost entirely bald in the parietal and frontal regions. Here the disease began seven weeks before, there were no "note of exclamation" hairs, but the hairs were broken off short in the follicles, giving a rough feeling like fine emery-paper when the finger was passed over the scalp, and a finely dotted appearance, which gives rise to the name by which it is sometimes known, of "Black dot ringworm." The patient was ordered Lin. Terebinth. Acet.



A. G., æt. 26, example of parasitic alopecia areata.

Malcolm Morris states that the disease is due to the Micresporon Andouini, *i.e.*, the small-spored fungus (which is the common cause of ringworm in children [p. 351-2], whereas the large-spored variety is found in tinea cricuiata, parasitic sycosis, and onychomycesis).

In all cases of *alopecia areata* stimulating applications give the best results—sometimes they are combined with mild antiseptics—indeed perhaps the last method is the most scientific and the most in favour at the present time.

Thus it will be noticed above that in his cases Sir Cooper Perry ordered Linimentum Terebinthinæ Aceticum (B.P.), a both stimulating and antiseptic application. With obvious neurotics, of course, nerve and general tonics are indicated; other suggested remedies have been the internal administration of thyroid extract, and injections of pilocarpine.

Alopecia senilis, or the baldness of advancing age, is by no means confined to old people; its earlier onset may be due to heredity or chronic dry seborrhœa.

At first there is simply thinning of the hair, and the change begins at the brow and extends to the occiput.

Among the many factors put forward as determining an indecently early onset of this senile change, have been the hard felt hat of commerce, and (uncharitably) alcohol or a life of dissipation; as the writer is himself beginning to get a little thin on the top, he is glad to be able to say that the last two at all events can be disregarded as having anything to do with the disease. There is also an elaborate auto-intoxication theory to be mentioned only to be dismissed. In the degree common in males, it is seldom seen in women, so the hard hat pressing on the blood-vessels, and thus interfering with the blood supply of the scalp, may have something to do with it.

Beyond actual old age, *i.e.*, senile decay, it is now becoming generally recognised that seborrhœa is the predominant cause; and seborrhœa is practically certainly due to a micro-organism.

For dry seborrhœa—scurf causing—commencing baldness, Sir Cooper Perry has ordered as a hair-wash:—

Quin. Hydrochloridi	... ...	grs. 5
Spts. Rosmarini	... ...	ʒiii.
Aq. ad.		ʒj.

or again:—

Hyd. Perchlor. ...	... ...	gr. ½
Ammon. Chlor. ...	... ...	gr. 1
Spts. Rosmarini	... ...	ʒiii.
Aq. ad.		ʒj.

Generally speaking, however, the treatment of baldness is not very satisfactory. Cases of baldness occurring during or after diseases such as syphilis, typhoid, and scarlet fever are, only as a rule, temporary, and merely form a rather unimportant complication of the principal disease to which they are secondary.

Lastly it should be mentioned that hopes have been entertained of benefit in *alopecia areata* from the application of the ultra-violet rays of an iron spark lamp, and that X-rays themselves are a cause of baldness.

Change of Address.

Dr. H. Nunan Collier, from Woodhall House, Avonmouth, Bristol, to Constantia House, Dynas Powis, near Cardiff.

Dr. W. Collins Lewis, from Carmarthen to Beech House, Denbigh.

Mr. C. L. Palmer, L.D.S., from Guy's Hospital to Cynthia House, Newmarket.

Dr. Harold Tipping, from 96, Evering Road, Hackney, to Tyldesley, Palmers Green, N.

Mr. H. C. Visick, from Philadelphia to 1203, Wilcox Avenue, Chicago, U.S. America.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Notices.

Royal College of Physicians of London.

CHARLES MURCHISON SCHOLARSHIP IN CLINICAL MEDICINE.

The next Examination for this Scholarship will be held at the Royal College of Physicians of London, on Monday, the 11th day of April, 1904, and following days.

The Scholarship is open to any Student of Medicine who has been a registered Medical Student during a period of not less than five, and not more than seven years at a hospital in London or Edinburgh, recognised by the Royal College of Physicians of London or by the Medical Faculty of the University of Edinburgh, and whether holding a Medical qualification or not.

The Examination will be conducted both orally and in writing, and will include:—

(*a*) Examination of Patients, with reports on their cases.

(*b*) Questions on Pathology and Treatment, and

(*c*) Examination on Specimens.

The Scholarship is of the value of Twenty Guineas, and is tenable for one year.

Intending Candidates are required to send in their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than March 25th, with evidence of the duration of their Medical Studies from the Deans of their respective Schools.

(The Examination for 1905 will be held in the University of Edinburgh.)

Pall Mall East, S.W. EDWD. LIVEING, M.D.,
January, 1904. Registrar.

Examining Board in England

BY THE

ROYAL COLLEGE OF PHYSICIANS OF LONDON

AND THE

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

The following are the dates on which the Examinations will commence in the year 1904:—

FIRST EXAMINATION.

**Chemistry and Biology.*—Tuesdays, January 5th, March 29th, July 26th, September 27th.

Practical Pharmacy.—Wednesdays, January 6th, March 30th, July 27th, September 28th.

SECOND EXAMINATION.

Physiology.—Thursday, January 7th, Wednesday, March 30th, Thursdays, June 30th, October 6th.

Anatomy.—Friday, January 8th, Thursday, March 31st, Fridays, July 1st, October 7th.

THIRD OR FINAL EXAMINATION.

†*Medicine* (1st Paper).—Tuesdays, January 12th, April 5th, July 5th, October 11th. (2nd Paper).—Wednesdays, January 13th, April 6th, July 6th, October 12th.

Midwifery.—Thursdays, January 14th, April 7th, July 7th, October 13th.

Surgery.—Fridays, January 15th, April 8th, July 8th, October 14th.

*The Examination in Practical Chemistry will be held on Friday, January 8th, Saturday, April 2nd, Fridays, July 29th, October 7th.

†Candidates who registered as Medical Students before the 1st January, 1892, are not required to sit for the First Paper in Medicine.

The First Examination (Part I., Chemistry, and Part III., Elementary Biology) will be held in Manchester as well as in London provided there are at least ten Candidates in each subject. Candidates should state when sending in their applications whether they desire to be examined in Manchester or in London.

Synopses indicating the range of subjects in the Examinations in Chemistry, including Chemical Physics, Practical Pharmacy, Elementary Biology, Physiology, Forensic Medicine and Public Health, may be obtained together with the regulations.

NOTICE TO UNIVERSITY CANDIDATES.

Candidates are reminded that they should send with the Schedule of Certificates when applying for admission to the Final Examination, a certificate from the Registrar or other official of the University showing that they have passed Examinations in the subjects of the earlier Examinations of the Board.

FREDERIC G. HALLETT, Secretary.

Specialities.

Liquor Carbonis Detergens.

We have received a sample of this well-known preparation from the proprietors, Messrs. Wright, Layman and Umney, who are, we believe, large drug contractors to the hospital.

The use of coal tar in dermatology has been placed beyond the experimental stage by work carried on in this country and America, and this well-made article supplies the demand for a reliable preparation.

It is a dark brown alcoholic solution of a rather agreeable odour in which naphthalene and phenols predominate; when diluted with water even to a large extent, the emulsion formed is of a whitish colour and, which is rather important, shows no separation of the constituents into globules.

It is recommended by skin specialists, to be used either undiluted, diluted, or in combination with other drugs such as lead subacetate, ammoniated mercury or zinc oxide, or as an ointment with a basis of vaseline and lanoline.

It should be noted that the above name is registered, and its use should be insisted on by prescribers if it be desired to avoid the many imitations among which we must enumerate the British Pharmacopœial Liquor Picis Carbonis.

Nursing News.

MATRON'S OFFICE.

Nurse Millidge, Head Nurse in Astley-Cooper ward, left the hospital on January 2nd, 1904. Nurse Mackenzie was transferred from the Out-patient department to Astley-Cooper.

Nurse Boodle, Head Nurse in Patience, left the hospital on January 8th, 1904, on completion of her training. Probationer M. Harvey was appointed to succeed her as Head Nurse in Patience.

Nurse Wise left the hospital on January 9th, on completion of her training. Nurse Thorpe was transferred from the Out-patient department to succeed her as Head Nurse in Naaman, and Probationer Bingham was appointed Head Nurse in the Out-patient department.

Nurse L. Wood, Head Nurse in Bright ward, left the hospital on January 13th, on completion of her three years' training, and Probationer Moore was appointed to succeed her as Head Nurse.

On January 25th, Nurse Jenkins left the hospital on completion of her three years' training to take up her duties on the Private Nursing Staff.

Nurse Nawn, Head Nurse in Stephen, left the hospital on completion of her three years' training to take up her duties on the Private Nurses' Staff.

On January 12th, Probationer Denton was appointed Head Nurse in the Surgery.

Physical Society.

Clinical Evening.

A MEETING of the Society was held on January 16th, at 8 p.m., in the Wills Library, Mr. K. Black being in the chair. There were forty-three members present.

A very interesting discussion occurred on the following cases:—

1. Separation of the lower humeral epiphysis, treated by full flexion of the elbow joint. Skiagrams were exhibited which clearly demonstrated the good apposition of the fragments obtained by this treatment. Skiagrams of similar cases treated by the more usual method of semi-flexion in semi-pronation showed much greater displacement. The radial pulse was not diminished. Mr. Malleson.

2. Salivary calculus impacted in Wharton's duct, with secondary salivary fistula into the mouth, and induration of the submaxillary gland. Mr. Wallace.

3. Traumatic epilepsy with paresis of forearm, probably due to cortical cyst or hæmorrhage at the site of an old shell wound. Mr. Pye-Smith.

4. Chlorotic anæmia with secondary lateral sclerosis in a man. Mr. Jenkins.

5. Gumma of the tongue. Mr. Clarke.

6. Arthritis of the knee of a doubtful nature. Mr. Bowle.

7. Hernia cerebri with diminishing hemiplegia. Mr. Leeming.

8. Pseudo-hypertrophic muscular paralysis. Mr. Malcolmson.

The following members contributed to a lively discussion: Messrs. Pye-Smith, Malleson, Morland Smith, Bowle, Bowen, Wallace, Jenkins, Stevenson, Mann, Robinson, N. I. Spriggs, Clarke, Malcolmson, Leeming, and the Chairman.

A vote of thanks to the Chairman and the exhibitors of the cases was then proposed by Mr. Mann, seconded by Mr. Alcock, and carried with acclamation; and the meeting terminated with coffee at 10.30 p.m.

The next meeting will be held in the Smoking Room at 8 p.m., on Saturday, January 30th, when Mr. P. A. Peall will read a paper on "*The Present System of Treating Fractures.*" Mr. G. A. Ticehurst will preside.

Appointments.

Civil.

BEACH, H. W., M.R.C.S., L.R.C.P., has been appointed *Medical Officer of Health to the Yarmouth Town* Council.

FAGGE, R. H., M.R.C.S., L.R.C.P., has been appointed District Medical Officer of the Melton Mowbray Union.

MORICE, CHARLES LLOYD, M.R.C.S., L.M., L.S.A., has been appointed a member of the Senate of the New Zealand University.

STAMM, L. E., M.D., B.A., B.Sc., has been appointed Medical Officer to the British Home and Hospital for Incurables, Streatham Common, S.W.

WOHLMANN, A. STANLEY, M.D., has been appointed a member of the Rotorua Town Council, *vice* Dr. Kenny.

Military.

CAPTAIN J. C. B. STATHAM, R.A.M.C., has been selected to attend a course of study at the Royal Army Medical College in London.

Presentation.

Dr. W. S. BROWN, the Parramatta (N.S.W.) local champion golfer of the past season, and winner of a handsome cup, was lately presented with the trophy. The presentation was made by Dr. Bowman, president of the local golf club.—*The Australian Medical Gazette,*

In Lighter Vein.

STAFF HUNT FOR TREASURE.

ALL THE OLD WHEEZES PUNCHED.

The announcement that treasure had been secreted by the GAZETTE somewhere upon the hospital premises was a signal for a mad rush to the Park on the part of almost the entire Staff. "Custom not known, antiquity forgot," they jostled and hustled one another in a desperate attempt to secure the prize, and the spectacle presented was ludicrous enough. In less time than it takes to narrate, claims were pegged out beneath the trees, not however without a certain amount of quarrelling, and for some hours nothing was heard but the grating of pick and of shovel, and the occasional grinding of an axe.

[The pigeons, seeing our reporter was present, and scenting a forthcoming article, felt their reputation was at stake, and interested themselves deeply in the situation.]

One of the most extensive claims was that of Sir Cooper Perry and Dr. Shaw, who, working in conjunction, had turned out several cart-loads of earth when they chanced upon a new species of brick, which pleased them both so much that they decided to keep it. So absorbed were they in the contemplation of their find, that they abandoned the search and went home to tea with the brick wrapped up in paper.

Dr. Taylor was most careful in his selection of a claim; he wished to proceed scientifically or not at all, and since science was measurement—here Dr. Beddard interrupted him most rudely by saying that measurement was several sorts of a waste of time, and the only way to find out where to excavate was to percuss with the wrong end of the stick, and this he proceeded to do to the infinite amusement of both pigeons and ward clerks. Most of the treasure seekers fancied the Park as a likely place for a find, but Mr. Clement Lucas differed from the majority, feeling convinced that in the direction of the Bath was the most likely hiding place. In the Bath he found a Supinator of great size, which pleased him so much that he almost lost consciousness. Mr. Kenneth Black, his house-surgeon, agreed with him that it was most interesting. Mr. Dunn arrived upon the scene very late in the day, and standing in the background remarked, "There it is, my dear." He was immediately surrounded by an importunate crowd anxious to know what he meant, but he only said, "Bless you, I never mean anything."

Mr. James Marr Brydône happened to be passing, clothed in a bland smile and a divorce suit borrowed from his brother Adam; he immediately joined in the pursuit with zest, choosing what proved to be a particularly cunning part of the Park for excavation, for in less than no time, with the pointed end of his waxed moustache, he had made a hole in the underground passage leading to the Nurses' Home, and before you could say "Welbeck" he was through, and had written his name in the visitor's book.

Dr. Pitt, who took things very calmly, told our reporter that he remembered a similar case of buried treasure that caused just such another stir in a small village in the Fiji Islands in 1894—he was there at the time, and had been fortunate enough to secure a blood count from the finder.

Dr. Fawcett was unable to confine himself to one particular spot. He said that it was just one of those conditions that we sometimes meet with and have to be prepared for, and proceeded to make a minute perforation.

The President of the Residents who was allowed to try his luck, was handicapped by a lack of the necessary implements, but he sang "Rosey, you are my Posey" cheerily enough throughout his somewhat unsatisfactory search. His red face became still redder with exertion, and he announced his intention of keeping it up till morning as the Warden had kindly consented to allow him to absent himself for the night.

The treasure at last was found, and found by Mr. Hicks. He had come early on the ground with his cystoscope, and, after several nasty skirmishes with Dr. Jacobson, of the American Cystoscopic Company, Limited, had managed to get fairly started. At about six o'clock, when it was getting dusk, a muffled cry was heard from this claim, and shortly afterwards Mr. Hicks was seen steering off unconcernedly with a bulging waistcoat.

We may add that Mr. Hicks's find consists of a marred portrait of the late editor. There are many of these buried on the premises.

THE DAUNTLESS THREE.

Reviews.

The price of books submitted for review should in every case be stated.

The Prevention of Consumption. By A. Hillier (Messrs. Longmans, Green & Co.) 226 pp. 5s. net.

This work, recognising as it does, that in order to obtain the co-operation of the public to eradicate a most common cause of disease, it is necessary to educate them on the infectious nature of tuberculosis, is decidedly a step in the right direction.

We think it deserves every success, but at the same time fear that it is perhaps a little too technical for the ordinary lay mind.

Should another edition be required (and there is little doubt that it will be so), we would like to see a page or two introduced in the beginning of the book, describing and explaining in popular language the meaning of terms such as, to pick only a few, "consolidation," "cavitation," "incubation," "bouillon," etc., etc.

This is no small matter, seeing that the ordinary man, so great is the stress of time in the present day, has to be enticed almost against his will, to read a work of this nature.

The chapter on the Relation of Human to Bovine Tuberculosis is, considering the present difference of opinion, lucid and admirably stated.

The book has the further recommendation of having been revised by Professor R. Koch.

In effect, we congratulate Dr. Alfred Hillier on this highly commendable and altogether successful endeavour to enlighten the general public on a subject which deeply concerns themselves.

Manual of Massage. By Mary A. Ellison. 2nd edition. Revised by Gulielma Manley. 3s. 6d. net, 126 pages. (Ballière, Tindall & Co.)

In this modest little work a laudable endeavour is made to compress into a small volume, not only instruction in the practical and theoretical aspects of massage, but also as much anatomy and physiology as is deemed essential to its proper performance.

That part of the work dealing with the subject itself, including much excellent advice, is satisfactory. The chapter on Anatomy, although concise, must prove dull and difficult, unless the advice to visit the College of Surgeons frequently can be followed.

The diagrams are clear and accurate, and must prove helpful in obtaining even an elementary knowledge of anatomy. On the whole, this section seems likely to require some supplementation, if the author's *sine qua non* of a sound knowledge is to be achieved.

The physiology is elementary, but probably sufficient.

The volume also includes chapters on the Weir Mitchell and Swedish Systems, which are intended to render it complete, but seem barely essential to a work of this kind.

Elements of Surgical Diagnosis. By A. Pearce Gould. Third edition. New and revised. 607 pages. (Cassell & Company.)

This handy little manual, now in its third edition, is thoroughly revised and brought up to date.

Although of small size, the whole field of surgery from the point of view of diagnosis is fully considered and the matter concisely arranged. Wherever possible tabulation has been resorted to, and the different points numbered and arranged in order of importance, thus rendering their committal to memory simple. It is, above everything, an extremely useful volume for students preparing for their final examination.

A work of such a well-known nature, and by a man of such high standing in the medical profession, scarcely needs our encomiums, nevertheless we wish it every success.

The Latin Grammar of Pharmacy. By Joseph Ince. (Ballière, Tindall & Co.) 5s. net.

This little volume is now in its eighth edition, and there is no doubt of a real need of its further propagation, judging by the slovenly way in which prescriptions are still written.

To students preparing for the London University Examinations, who are expected to write out prescriptions in Latin in full, this book ought to find most favour. Subtended is a Latin-English vocabulary comprising most of the words used in medicine.

Atlas of Human Anatomy. By Carl Toldt (Vienna). Translated from the German by M. Eden Paul Rebman. Part I., Regional Anatomy and Osteology. Part II., Arthrology. 6s. net.

These will be found useful to students in conjunction with their anatomy books.

The diagrams, exhibiting both joints and bones from every point of view, are clear and accurate, and define well the relations of neighbouring structures.

The names are printed opposite their corresponding objects, thus dispensing with the use of numerals which are, as a rule, so fatiguing and cause so much waste of time in the usual text-book illustrations.

To many who have allowed this subject to get a little rusty, these volumes will be found useful as a quick and simple means of refreshing the memory.

Altogether we think the work deserving of success, and hope the remaining four parts will maintain the same standard of excellence.

Bob Sawyer in 1823.

THE following extract is taken from the pages of a paper called the *Mirror* (vol. I.), which was published in 1823, a time when chloroform was a thing unknown, and aseptic surgery a dream of the far-distant future:—

There is something particularly "piquant" in the small-talk of gentlemen of the medical profession. I wel recollect the conversation of two young surgeons, who were sitting in the next box to me in a coffee-house near Great Marlborough-street.

"Oh! by-the-bye, John, I got the finest subject yesterday you ever saw."

"Ay! where did you get it?"

"From France, to be sure, and never saw a fellow so neatly packed; by Jove, he was as round as a ball."

"What was the damage?"

"Oh, the fellow who sent me him said if I would send back the hamper full of beef, he should be satisfied; so I sent him a trifle."

"Have you any part to spare? Waiter, another chop."

"Why, you may have a limb reasonable."

"Well, then, next week; but just at present I have a very pretty small subject."

"What did you give?"

"Two shillings an inch, but the cursed fellow had pulled the child's neck almost out of joint, to make it an inch longer. But didn't I tell you of the fun we had at B——'s? You know we had that fellow who was hanged on Wednesday for murdering his grandmother. Well, he was devilish ill-hanged, and so we thought we'd galvanise him. We got the battery ready (you know its a pretty strong one) and, as soon as it was applied, the fellow—but won't you have some more porter? (Waiter, another pint of porter)—the fellow lifted up his brawny arm and threw it twice across his chest. The men were all delighted, but our Irishman, O'Reilly,—you know O'Reilly, who nearly got into a scrape with cracking the crown of the sexton of St. Pancras—O'Reilly, who was standing by, with a stout board in his hand, no sooner saw this movement than, not quite understanding the affair, and fearing that the fellow was actually coming to life again, he caught him a thwack on the side of the head which made the cerebellum ring again. 'Is it he is going to walk?' cried Paddy—thwack— 'and shall Justice be *defated*?—thwack—and shall I be *chated* out of me shaving money?—thwack. By Jasus, gentlemen, an' I've floored him, sure.'"

"Capital," cried John, "I wish I had been there. But have you heard about Astley-Cooper's operation?"

"No, what was it?"

"Why, he whipped off a child's leg in thirty-eight seconds and a half; the child didn't know what he was about, and only asked what was tickling it so."

"Clever that, by Jove. Do you know who is likely to get St. Thomas's?"

"Why, some say A, and some B. I know B's friends have subscribed for thirty new governors. Have you seen the new tourniquet?"

"No, but I am told it is clever. By-the-bye, where do you get your knives from?"

"From Millikins."

"And your books?"

"I always go to Callows."

"I say, I don't think you have changed your dissecting coat, have you?"

"Hush, hush; the people in the next box will hear; they all think now it is the woodcock, a little too gamey."

This was quite sufficient for me; I had been for some time aware of a strange odour, but I had laid it to the account of the woodcock. No sooner, however, did I discover the true origin of it, than throwing down my money and seizing my hat, I hastily sought the open air.—*Mirror*. March, 8th, 1823.

Pass List.

University of Cambridge, January, 1904.

DEGREE OF BACHELOR OF SURGERY.

J. H. Donnell. C. M. Murray.

Second Conjoint Examination.

F. J. Cutler, J. S. Farnfield (4 years regulations), W. R. Greening, G. R. Phillips, S. A. Piper, J. L. Rankine, H. W. B. Walling, J. A. von Wiehe, R. Willan.

First Conjoint Examination, January, 1904.

CHEMISTRY.—C. H. Douglas, C. M. Plumptre, O. J. Roots (L.D.S.), C. R. Rudolf (L.D.S.), B. B. Samuel (L.D.S.), A. V. St. John, H. J. Weighell (L.D.S.).

ELEMENTARY BIOLOGY.—C. H. Douglas, H. W. Heasman, E. P. L. Hughes, V. P. Hutchinson, H. R. Mullins.

PRACTICAL PHARMACY.—A. R. Beaumont, L. H. Burner, G. H. Cheyney, J. E. Collins.

A few Notes on Four Cases of Fibroid Complicating Pregnancy.

CASE 1.—First pregnancy. Patient came up because she had discovered the tumour in her abdomen. There was a tumour about the size of a big orange, situated on the anterior aspect of the fundus uteri. It was fairly sessile. The uterus was enlarged up to a point between the umbilicus and pubes. Patient was advised to go to term. She came back and was delivered of a living child without any difficulty.

CASE 2.—Æt. 41. Four months' amenorrhœa. The uterus was pushed up to the level of the umbilicus and inclined to the right side. There was a large, hard, firmly-fixed tumour in Douglas' pouch low down. The os uteri could not be reached per vaginam. There were symptoms of pain and difficulty in passing urine. A posterior cervical fibroid was diagnosed, complicating a four months' pregnancy. The tumour was situated absolutely beneath the ovum, and it was with difficulty that the fingers could be pressed into the vagina toward the cervix.

CASE 3.—Æt. 36. Came up because of pain and difficulty in micturition. On examination the signs were practically the same as in Case 2, but there was if anything a little more room in the pelvis. A diagnosis of four months' gestation, complicated by a posterior cervical fibroid, was made, and the patient was advised immediate operation.

CASE 4.—Æt. 29. First pregnancy. Four months' amenorrhœa. Came up complaining of pain and difficulty in passing urine. On examination a reversed condition of Cases 2 and 3 was found. A large tumour about the size of a five months' pregnancy was found extending up to two inches above the umbilicus. This was obviously not the pregnant uterus. On vaginal examination another soft elastic tumour, which hardened and relaxed, was found in Douglas' pouch low down. The cervix could not be reached. Here, therefore, was a large hard tumour lying anterior to the uterus, and forcing the latter downwards and backwards into the pelvis. Dr. Horrocks advised operation without delay on account of present symptoms and future dangers.

In these four cases one has excellent examples of the various positions in which a "fibroid tumour" may be found complicating pregnancy. The dangers of such a condition are many during pregnancy, but especially during labour, and it is necessary to consider not only what may happen during the pregnancy, but prognose what will happen at the time of labour. The latter is by far the more important and the more anxious.

There are two distinct ways of looking at such cases, (*a*) the effect of pregnancy and labour on the tumour, (*b*) the effect of the tumour on the labour.

In the former (*a*) the effect on the tumour is not so important as in the case of ovarian cysts, and since it does not enter into the above cases it is best not to discuss this point. (*b*) The effects of the tumour complicating pregnancy and labour are most serious and most difficult to prognose. The chief dangers are: (1) Abortion or miscarriage, (2) Malpresentations, (3) Obstruction, (4) Post-partem hæmorrhage, and (5) Uterine inertia, with their many dangers.

These four cases came into Queen ward under Dr. Horrocks and Mr. Targett during the early months of pregnancy; thus, in all four cases, the question of what was best to be done had to be discussed, and the probable course of the pregnancy and labour prognosed.

One of the most important points that at once comes up is the question "Will this tumour obstruct labour at term?"

To decide this point one must first consider the relation of the tumour to the uterus. Is it at the fundus, at the lower zone, or at the cervix?

In Case 1 the tumour was at the fundus, and in such a position it is hardly likely to cause mechanical obstruction to the descent of the fœtus at term. Therefore, such a case has only to face the dangers of malpresentation, post-partem hæmorrhage and uterine inertia. Mr. Targett advised that the patient should go to term, and since then the patient has had a living full-grown child without difficulty. The tumour in question was a sessile one and it diminished very much in size as the uterus involuted. If it had been a sub-serous pedunculated tumour, it might have caused trouble by falling back into Douglas' pouch, but this was not so in this case. If the tumour were situated in the lower segment of the uterus and sessile, the question of obstruction would be more difficult. It was the general opinion at Swansea last year, that tumours so situated most often become drawn up towards the fundus as labour progresses. Therefore this would seem an indication to leave such tumours alone until labour should come on, so that a chance may be given for elevation of tumour to take place by natural means, and failing this to perform Cæsarian Section if a living child is wanted, or if the obstruction is absolute. Of course, if the obstruction is relative, forceps may be applied and the child delivered alive, and failing this, craniotomy may be performed.

In Cases 2 and 3 the tumours were sessile and situated at the posterior aspect of the cervix uteri. Even at the fourth month the obstruction was almost "absolute." The fœtus seemed to lie on the fibroid shelf. Pressure symptoms had clearly begun. There was no chance of delivery at term by natural ways. A four months' fœtus could hardly be expected to pass such a long narrow canal as existed in these cases.

It is nearly unanimously agreed, that to induce a miscarriage in this kind of case is very dangerous for the mother. It is difficult to get past the obstruction even to bring about this result, and much more difficult to empty the uterus as one may have to do, either on account of hæmorrhage, or from some such accident as

an adherent placenta. The results are disastrous. The only treatment to discuss then is the question of immediate operation, or Cæsarian Section at term.

It would not be wise to let such cases as 2 and 3 go to term, inasmuch as the pregnancy had in each case at least five calendar months to run, and fibroids grow rapidly during pregnancy. There was no indication that such tumours would rise out of the pelvis, for they were already fixed fast, and pressure symptoms were becoming marked. Thus the most satisfactory course was to take radical measures, and remove the tumour together with the ovum and uterus. In small cervical fibroids, whether they be polypoid or sessile, it might be possible to cut off or enucliate the tumour; but in these cases the tumour was far too big for such treatment.

In Case 2 it was found impossible to get the fibroid up out of the pelvis; therefore Mr. Targett decided to do a "Supra-vaginal hysterectomy," taking away the ovum and uterus, and leaving the tumour behind. The patient was 41 years of age, so that the tumour was not likely to go on growing in the future, and also it was most probable the tumour would decrease rapidly in size as soon as the pregnancy was ended. This is what happened, and the patient went out with no pressure symptoms, and the tumour much reduced.

In Case 3, Dr. Horrocks removed uterus, ovum and tumour, and the patient did extremely well.

The tumours in both these cases were larger than fœtal heads at term.

In Case 4 there was a large tumour (size five months' pregnancy) in front and to the right, so situated that it forced the pregnant uterus downwards and backwards into the pelvis. The pregnant uterus could be felt per vaginam with its fundus turned backward into Douglas' pouch, the cervix was almost out of reach high up above the pubes. Pressure symptoms on the bladder were clearly present.

It was not possible to tell the exact relation of such a tumour to the uterus, but it was quite clear that the tumour was in front of, and retroverting, the pregnant uterus. The patient had already suffered from retention of urine and she was four months pregnant. If such a condition were not relieved it would necessarily lead to disasters such as cystitis and secondary kidneys, or abortion and its dangers during pregnancy, and even if the patient should survive these dangers and go to term, a tumour of this size must have resulted in serious mechanical obstruction as well as alteration in the uterine axis. Apart from these serious dangers, it did not seem possible that the abdomen could hold a full-term pregnant uterus as well as so big a tumour.

Dr. Horrocks decided to operate. On opening the abdomen, a large fibroid was found growing apparently from the anterior aspect of the right broad ligament, close to, or from, the round ligament. It had twisted itself into an anterior position in relation to the pregnant uterus, which was forced into the pelvic cavity. The right tube and ovary were lying free behind the tumour.

On account of its slight attachment to the uterus, Dr. Horrocks decided to remove the tumour and leave the pregnancy undisturbed. This was truly most conservative surgery, for it has left the patient not only with her genital organs intact, but the ovum is progressing satisfactorily in its uterine existence. The tumour in question was shelled out of its bed with only slight hæmorrhage. The patient is quite well and there were no signs of any attempt at miscarriage.

These four cases seem to give a very good idea of the treatment of fibroid tumours during pregnancy. The treatment at term is another question.

The two great points to keep in mind, in deciding what to do for these cases which come up during pregnancy, are:—(1) The position of the tumour in relation to the uterus and thus in relation to the ovum. (2) The size of the tumour.

These four cases all did well. Two of them were under the care of Dr. Horrocks and two under Mr. Targett.

H. T. HICKS.

Guy's Hospital.

January 11th, 1904.

In accordance with annual custom, the House-Committee publishes for the information of the Medical, Surgical and Nursing Staff the following tables showing the total number of patients sent during the past year to the various Convalescent Homes connected with the Hospital, and the amounts found in the Ward Collecting Boxes, with Special Donations:—

Wards.	No. of Patients. 1903.	1902.
Astley-Cooper	41	56
Cornelius	37	28
Lazarus	28	43
Job	26	39
Luke	26	29
Naaman	39	25
Patience and Samaritan ...	33	30
Charity	35	30
Dorcas	30	35
Queen Victoria	91	92
Martha	46	41
Lydia	38	40
Eye-Wards	14	3
Addison	83	78
Stephen	51	54
Mary	74	87
Clinical	74	107
Isolation	2	0
Esther	22	0
Surgery	11	0
Out-Patients...	67	85
	868	902

The subjoined list gives the distribution of the patients amongst the various Convalescent Homes :—

Ascot...	169
Barnet	4
Bexhill	18
Bognor	25
Broadstairs	107
Folkestone	3
Hanwell	2
Hassocks	2
Hayes	8
Margate	4
Ramsgate	2
St. Leonards	1
Swanley	291
Ventnor	3
Walton	62
Worthing	167
Total	868

List of amounts received from patients in the various Wards, and sums found in Ward Collecting Boxes, &c., for the year ending December 31st, 1903. The amounts received in the previous year are inserted for the purpose of comparison :—

	Box Collections. 1903. £ s. d.	Special Donations. 1903. £ s. d.	Box Collections&Special Donations. 1902. £ s. d.
Hospital Front Gate	13 8 8	—	16 3 2
Porter's Front Lodge	3 17 10	—	5 5 7
Counting House	1 0 0	—	0 3 3
Secretary to the Treasurer's Office	1 1 0	—	0 5 0
Conservation Room	3 3 0	—	9 9 0
Out-Patient Department	148 7 1	—	151 14 5
Surgery	9 18 5	—	12 9 9
Addison Ward	9 13 1	—	68 12 1
Astley-Cooper Ward	1 8 2	1 1 0	9 5 11
Bright „	3 2 10	4 14 0	26 13 6
Charity „	5 4 7	—	31 6 6
Cornelius „	1 4 3	—	1 14 3
Dorcas „	1 2 8	5 15 0	13 9 2
Esther „	1 2 3	—	—
Job „	11 10 4	13 13 6	4 1 1
Lazarus „	6 6 7	2 2 0	15 15 6
Luke „	14 11 4	13 0 0	3 2 1
Lydia „	6 14 1	—	3 3 1
Martha „	4 14 9	13 16 6	6 7 3
Mary „	3 3 9	3 3 0	6 6 10
Naaman „	3 1 9	31 2 6	13 12 2
Patience „	0 6 11	3 3 6	3 3 11
Eye „	27 15 11	3 3 6	45 5 3
Stephen „	1 6 10	2 2 6	31 6 9
Queen „	3 1 8	25 3 6	30 11 10
Victoria „	2 0 0	—	5 8 6
Clinical „	1 14 6	—	11 9 4
Newcomen Gate	—	—	0 1 0
	297 0 2	120 11 0	525 8 4
Total ...	£417 11 2		

Sport.

Football Fixtures.

SATURDAY, JANUARY 30TH.

G.H.R.F.C., I., v. R.I.E.C., home.
III., v. Blackheath School, away.
G.H.A.F.C., I., v. West Kent, away.
II., v. Central Technical College, home.

SATURDAY, FEBRUARY 6TH.

G.H.R.F.C. I., v. Kensington, away.
II., v. Kensington II., home.
III., v. Wasps III., away.
G.H.A.F.C., I., v. Ewell, away.
II., v. Ewell II., home.

WEDNESDAY, FEBRUARY 10TH.

G.H.R.F.C., II., v. St. Thomas's "A," home.
III., v. Dulwich College II., away.
G.H.A.F.C., I., v. R.I.E.C., away.

SATURDAY, FEBRUARY 13TH.

G.H.R.F.C., I., v. Lennox, away.
II., v. Lennox II., home.
III., v. Lennox III., away.
G.H.A.F.C., I., v. Emeriti, away.
II., v. Surbiton Hill II., home.

Rugby Football.

Guy's v. Rosslyn Park.

This match was played at the Old Deer Park on Jan 16th. Guy's pressed at the start, and Morgan attempted a drop at goal from a free kick, but failed. The scrums were very loose and the Guy's forwards were packing badly. Morgan intercepted a pass at the half way line and scored a good try after dodging the back, Tolhurst failing to improve. Soon after this Morgan picked up from a scramble and passed across to Alcock, who scored far out, McEvedy failing, The rest of the first half was played in the Rosslyn Park side of half way, except when their forwards rushed the ball down the field on one or two occasions. Our halves got off side in our 25 at a scrum, and Rosslyn Park kicked a fine goal from the touch line. Soon after this the only good bout of passing among our backs ended in Alcock being pusbed into touch near the goal line. Rosslyn Park got the ball from nearly every scrum, and Lewis, one of their halves, made the most of his chances, one of the three-quarters tackled well, and so prevented the fast wing three-quarters doing any damage. Half time, Guy's 2 tries. Rosslyn Park 1 penalty goal.

After half-time our forwards went to pieces. They never got the ball and did not push or pack well. Rosslyn Park heeled very well, but the passing of their three-quarters was not good. If they looked at all dangerous Morgan or McEvedy came to the rescue and brought their men down in great style. There were several free kicks given against the Rosslyn Park halves, none of which were improved upon. Our forwards occasionally broke away with the ball, but generally lost it by kicking too hard. Once King-Stephens nearly scored from a long run, but was collared by Morgan near the goal line. We nearly scored through Alcock and some of the forwards twice. There was no more scoring, so Guy's won by 6 points to 3.

Our three-quarters were good in defence, but Jones was bad in attack. He tried to run through instead of passing. The halves were slow, but were rather hampered by the offside play of their opponents. The forwards were very bad. Did not push at all well and lost the ball nearly every time. Saunders winged badly, and as a result shone in the loose. Archer was good, but kicked too hard. Harrison tried to run too much instead of kicking. He has played three-quarters too often, and seems to like scoring tries.

Papers by Guy's Men.

A Case of Purulent Pericarditis associated with Empyema in a Child aged two and a half years. Operation. Death four months later. By Dr. J. A. Coutts and R. P. Rowlands, M.S., F.R.C.S.—*British Medical Journal*, January 2nd.

A case of Rodent Ulcer treated with Radium. By Gerald Sichel, F.R.C.S. (Illustrated).—*British Medical Journal*, January 23rd, 1904.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. G. H. Cheyney (Dr. Taylor); O. V. Payne (Dr. Hale White); A. R. Beaumont (Dr. Pitt); A. F. Hertz (Sir Cooper Perry).

Clinical Assistants in Surgical Wards.—Messrs. T. Turner (Mr. Lucas); M. J. Mottram (Mr. Golding-Bird); W. N. May (Mr. Jacobson); R. O. Williams (Mr. Symonds).

Ophthalmic Dressers.—Messrs. M. Maher, F. B. Lowe (Mr. Higgens, February 1st); A. M. Benett, A. V. Maybury (Mr. Brailey, February 1st); F. P. Hughes, E. Lloyd (Mr. Higgens, March 16th); R. Edridge, W. Reeve (Mr. Brailey, March 16th).

Surgeons' Dressers.—Messrs. H. P. Costobadie, J. E. Scales, J. A. C. Greene, A. H. Clough, C. W. R. Preston, W. C. Mc N. Dickey (Mr. Lucas); R. P. Lewis, H. M. Langdale, G. F. Greening, N. H. Oliver, A. Morris, R. D. Barron (Mr. Golding-Bird); H. V. Mitchell, H. C. Cameron, G. H. MacAlister, M. McPherson, V. A. P. Costobadie, A. D. Crofts, M. de L. Robinson (Mr. Jacobson); R. A. Chisolm, A. H. Miller, A. B. O'Brien, R. E. French, R. W. Allen, F. D. Crew (Mr. Symonds).

Externs.—Messrs. A. Leeming, F. M. Longson, H. D. Wyatt, L. J. Orpen, C. M. Stevenson (February); S. M. Wells, H. M. Clarke, F. Alcock, E. C. Hughes, E. W. Sheaf, L. G. Davies (March): A. B. Cocker, L. Doudney, R. Felton, P. A. S. Dyson, C. M. Wenyon (April).

Calendar.

January, 1904.

Sat. 30.—Physical Society's Meeting at 8 p.m., Paper by Mr. P. A. Peall on "The Present System of Treating Fracture."

Fri. 5.—Test Exams. for Revision Classes for Final L.D.S. Eng., begin.
Special Exam., Part I., for L.D.S. Eng.

Sat. 13.—Physical Society's Meeting at 8 p.m., Pathological Meeting.
Physical Society's Dinner at 6.30 p.m.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Births.

HAYWARD.—On January 8th, at 65, Stert Street, Abingdon, the wife of M. Cecil Hayward, M.A., M.B., of a daughter.

REID.—On January 16th, at Lyndholme, Chertsey Road, Woking, the wife of Percy J. Reid, L.D.S., of a son.

WORTHINGTON.—On January 9th, at Hurst House, Chesterfield, the wife of Sidney Worthington, M.D., of a son.

Deaths.

NISBET.—On January 9th, at 11, Heene Terrace, Worthing, Frederick John Nisbet, M.R.C.S., L.R.C.P., aged 39 years.

STEVENS.—On June 9th, 1903, at 10, The Court, Guildford, very suddenly, Robert Ingram Stevens, M.R.C.S., L.S.A., late of Hoddesdon, Herts.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 412.] FEBRUARY 13, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	61–64
Atrophic Rhinitis. Clinical lecture by Mr. F. J. Steward	64–69
Guy's Hospital Debating Society	69
Hospital Types	70
Dental News	70
Guy's Hospital Christian Union	70
Notices	71
Chapel Notices	71
Correspondence	71
Appointments	71
Papers by Guy's Men	71
Officers' and Servants' Dinner	72
The Present System of Treating Fractures	72–77
Acute Cardiac Dilatation	77–78
Pass List	78
Sport	78–80
Change of Address	80

Passim.

NOW that hostilities have broken out between Japan and Russia, a fresh chapter has commenced in the annals of military surgery, while the vexed question of naval ambulance will be receiving the attention of naval medical officers of all nationalities. We do not know precisely what Guy's men may be at or near the seat of war, but communications from any one of them on current events will be most welcome to us here in England.

THE latest recrudescence of Bumbledonian ignorance and malice, so incorrectly styled a "Guy's Scandal," has not subsided so soon as we had expected. The worthy Bumble is appealing unto Cæsar in the shape of the Committee of King Edward's Hospital Fund and we await events. It is a satisfaction to know that this hospital has nothing whatever to fear in the way of an expert enquiry into its organisation; as one of the best managed hospitals in the kingdom it has everything to gain and nothing to lose from such a proceeding. But it is for an expert alone to pass an opinion and not for any twopenny-halfpenny agitator, however high an official position he may hold in the councils of the borough. Throughout the whole windy business the attitude of the Press, with one or two exceptions, has been most reprehensible, the *St. James's Gazette*, for instance, made no mention of the Hospital's reply to the Southwark Guardians, although it had been only too ready to state the case from the point of view of the latter. One paper complains bitterly of the autocratic attitude of the Hospital towards its critics. When we consider the incapacity of the average layman to grasp the most elementary simple facts having relation to medicine, it is small wonder that his "criticism," which is really only blatant assertion, should annoy even the most benevolent despot. Another paper suggests the institution of "genuine democratic control" of hospitals. We would recommend this idea to a cartoonist, for he is the only person who could do it justice.

THE Dressers in the Surgery will merit the sympathy of their fellows for some weeks to come. For some time past we have heralded his advent in the Surgery, and now the British workman has arrived "terrible as an army with banners." He is to turn his attention at first to the Women's, which is accordingly closed for alterations, and the Men's at present does duty for both as regards surgical patients, the extension of Cornelius being used for female medical

cases. Under these circumstances the dresser's life will not be as happy as usual. *A propos* also of the alterations, the official name of the future Drunk or Dying has still to be decided upon. A good suggestion, we think, is to call it Samaritan, leaving the old ward upstairs with the simple and appropriate title of Patience only. The name Samaritan is much more suited to a ward of this character, if we are forever to be saddled with names having a strong Scriptural flavour.

Much has been said concerning after-dinner oratory, and much more could be said were it not for common politeness and a haunting fear that we may ourselves be some day pilloried and unable to escape. It is certainly true that your teetotaller sees most of the game on these occasions, and his verdict is far less charitable than is that of the vinously inclined majority. The average hospital after-dinner speaker is no exception to this rule, and it was, therefore, delightfully refreshing to find the exception holding good for once in a way at the annual dinner of the Guy's Hospital London University Club. Considerable care had been taken in the selection of speakers, and the results were in all cases most happy. One observation made by Dr. Shaw is well worthy of record. This speaker dwelt on the fact that the love of Guy's men for their Hospital was very deeply rooted and had its origin in the fact that the men, as students, were entrusted with a considerable amount of responsibility, far more than is the case at most other hospitals. This confidence in their trustworthiness engendered a responsive feeling of gratitude which still made itself felt long after student days were over. All will realise the truth of this assertion; for in comparison to very near neighbours, the lines have fallen in pleasant places for those holding appointments, and so long as our standard of capability remains what it is, there is little fear of alteration of the existing régime.

The desirability of forming exclusive and peculiar clubs from among the present men at the Hospital is most certainly a debatable point, but there can be no two opinions as to the desirability of reviving the Contemporaries Club, for that is an institution which affects, in the main, men who have left the place, and the taint of clique and coterie which hangs about the doings of the former, does not apply in the case of this latter club. The last batch of Contemporaries dates back to the early nineties, since then no club has been formed and men of the same year from that time up till now have not had, and will not have, suitable opportunities for meeting one another as have their more enterprising predecessors. Surely it is a mistake from the point of view of the men to let so excellent a custom die out, whilst from the point of view of the Hospital, as a whole, it most certainly is an undesirable state of affairs. It must be within everybody's experience that in the case of schools and colleges, those particular institutions whose Old Boys' associations are well organised, are certainly benefited in many ways by the active interest taken by the past in the doings of the present. The Contemporaries Club is obviously analogous to these last, and the sooner it is revived, as has been suggested of late by some more enterprising spirits, the better for the men when they leave Guy's, and the better for the Hospital as a social body.

For the last few years the Guy's Smoking Concerts have been signal successes, and we are glad to hear that the Residents have decided that March shall not go by without yet another celebration of convivial rites, which it is hoped will be counted among the great events of the Winter Session. The actual date fixed for the Smoker is March 12th, and Mr. George Evans is to be congratulated on his securing Mr. Dunn as chairman on this occasion. The proceedings will be somewhat novel, for in addition to the appearance of all the well known "Stars" in the first half of the programme, there will be presented in the second half a new and original melodrama in five acts, entitled "The Fast Male: or, A Curate is a Man." This play will be produced under the personal direction of the author, a gentleman who has already achieved fame in the paths of chronicity, but whose name wild horses will not drag from us.

It remains for the curious to await the fall of the curtain on the eventful night. The caste comprises many well known names, and also one or two that are at present unknown at our Smokers. It is to be hoped that there will be a very large attendance of men of all years, and that old Guy's men will put in an appearance also, since it is the desire of those responsible to make this concert as successful as any previously held. The cover of the programme has been designed by Mr. Sichel, who has thus transformed an otherwise formal document into an excellent and appropriate souvenir.

Under ordinary circumstances a demand from a contributor for an explanation as to the non-appearance of his effusion in our columns would be consigned to the waste paper basket without a shadow of compunction, but the letter received from the Debating Society, which we print elsewhere, is amusing enough in its effrontery to warrant not only reproduction, but also a comment. The society demands an explanation from the Gazette as to why its secretary's report of a meeting held in December last did not appear in the ordinary course in our issue of December 19th. It is true that the report was sent in as usual, and it is also true that it was sent in in ample time for the printer, but it would have been an insult to the intelligence of our readers as a whole, and to the Society in particular, had not that particular article been suppressed by those best qualified to judge of its moral and grammatical shortcomings. The account of the debate in question would have done no credit to an illiterate policeman, and was throughout unpolluted by the ghost of an idea. That a secretary could send in such a report to a decent journal is culpable enough, but that he should have the incredible insolence to write complaining of its non-appearance is certainly a triumph of depravity.

We are afraid that the article dealing with The Sister may not produce the impression which the author originally intended it should. From long experience the latter has, no doubt, as have we all, very definite opinions on this subject, and is burning to speak his (or her, for the authorship remains a mystery) whole mind in such a way that there may be no doubt left as to his meaning. If it is possible to damn with faint praise, it is equally possible to reverse the procedure, and many a silent sufferer will regret that our contributor should have fallen into this latter error. Of course a really satisfactory account—that is to say, one malicious enough to be true—would probably be accepted as superlatively funny, and would cause much mirth even in the enemy's camp. This the writer probably anticipated, and, with a cunning which does him great credit, employs sarcasm as a sure and certain method of inspiring hatred and proclaiming the true nature of the type. Were it not that the article will probably be received with the thorough-paced scorn which comes of not quite understanding the writer's meaning, many might hope for a reply, but under the circumstances we dare swear that none will be forthcoming.

All will congratulate Dr. Taylor on his appointment as Lumleian Lecturer for the present year. His subject is to be "Some Disorders of the Spleen," and the lectures will be delivered at 5 p.m., at the Royal College of Physicians, Pall Mall East, on March 17th, 22nd and 24th.

There is ample scope at Guy's for a general Hospital Museum, and many will be glad to hear that a definite suggestion has been made by the Gazette Committee as to the formation of such a department. There are already on the premises several old pictures, curios and valuable relics of all kinds, which should form a nucleus for a most interesting collection in the future. Old Guy's men, who have in their possession articles of historic interest in connection with the Hospital, will be aiding an excellent project by making a present of the same to the curator of the museum, who, although he has no official existence at present, is for the time being represented by Mr. Wells, the Secretary to the Treasurer. It has been suggested that when the Pathological Museum is completed there may be one room

set aside for a collection of Hospital relics, etc., which should be of the greatest interest both to the past and to the present.

At a meeting of the Inter-Hospital Committee for the arrangement of the Assault-at-Arms, it was decided to hold the Boxing, Fencing and Gymnastic contests at the German Gymnasium, St. Pancras Road, on Friday, February 26th. The semi-finals of Light and Featherweights will be decided in the afternoon and the remaining items in the evening. Tickets 5s., 2s. and 1s., can be obtained from the Secretary, Mr. E. P. Minett. Subscriptions are also invited towards our share of the Cup and the expenses entailed by the use of the apparatus, etc., of the Gymnasium: in all, £5 are required from Guy's for these two objects. It is to be hoped that the enterprise will be supported by as many Guy's men as possible, not only by their presence at the Gymnasium, but by their aid in raising the necessary funds. In conclusion, we may state that the competitors are being assiduously trained by most capable coaches, and there is every reason to hope that Guy's will cut anything but a sorry figure.

Thanks to the co-operation of the Gazette and Clubs' Union authorities, the Honor Oak ground will shortly be provided with a covered stand, which should prove a most valuable asset in every way to what is already becoming a popular resort for the lovers of sport in South London. It is the present intention of the Clubs' Union Committee to commence the erection of the stand soon after the cricket season, in the hope that it may be completed by October. If we are to have as excellent a ground as will result from this innovation, it is earnestly to be hoped that Guy's will preserve its high reputation in both cricket and football, or otherwise the stand may prove somewhat of a white elephant.

Another Massage Class is being arranged to commence early in March, and Mr. Ormond will be pleased to receive the names of men wishing to join, with, at the same time, a statement as to the most convenient time for them to attend.

We most heartily congratulate Mr. Rowlands on the excellent results obtained by his class in the L.D.S. Special Examination in Part I. (General Subjects). Out of thirteen candidates from this Hospital, no fewer than eleven were successful. This is a most excellent result, reflecting the greatest credit on all concerned.

This evening, at 8 o'clock, there will be a clinical meeting of the Physical Society in the Library. Mr. George Evans will occupy the chair.

Atrophic Rhinitis.

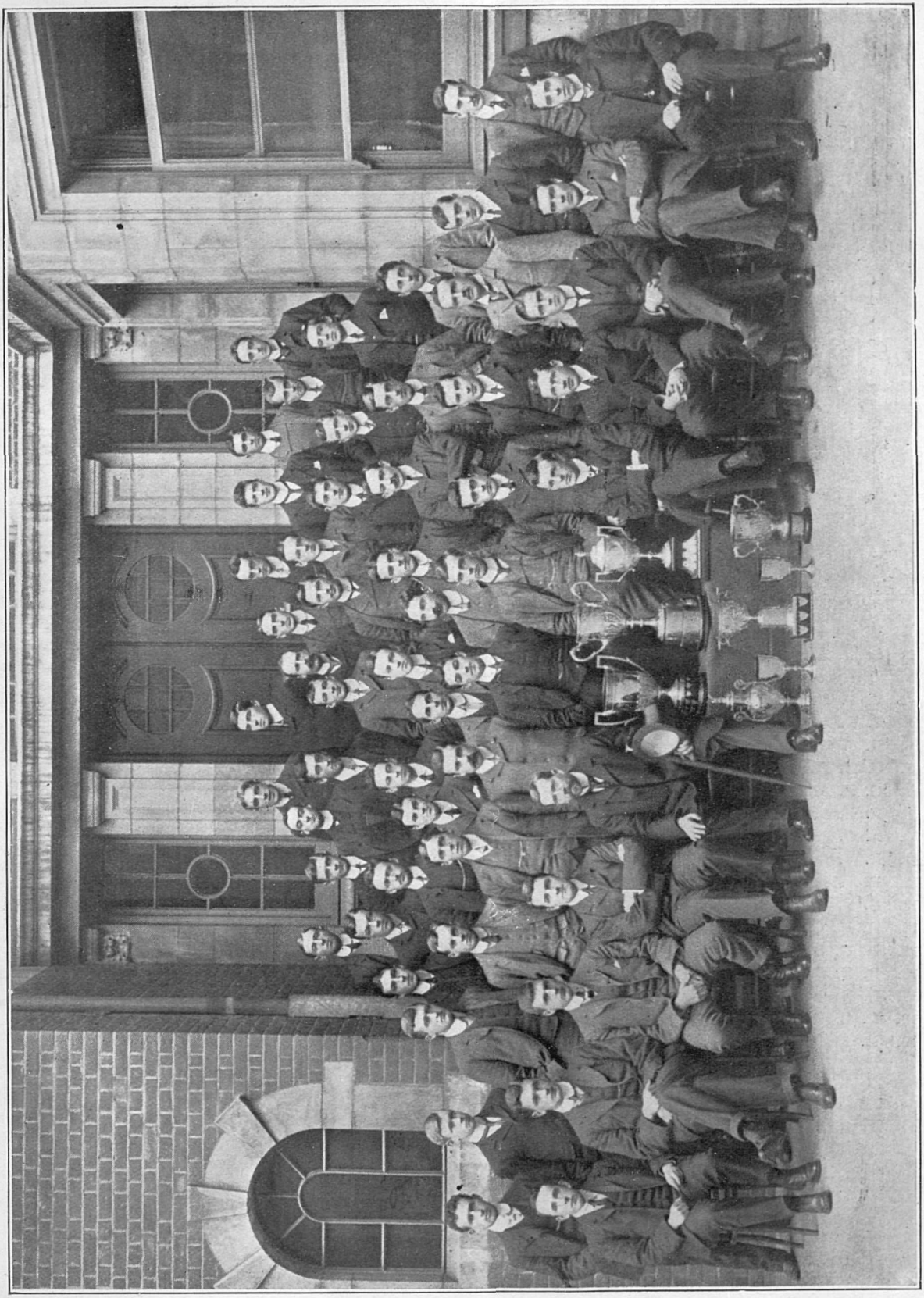
Clinical Lecture by Mr. F. J. Steward,

November 16th, 1903.

Gentlemen,—The disease which I am going to talk about this afternoon is an extremely interesting and important one. It is interesting first of all, because, from a pathological point of view, the disease, atrophic rhinitis, is so extraordinary. In fact, as I shall be able to show you later, the changes produced by it are quite unique and quite different from anything found in any other part of the body. In the second place, it is important that you should know something about this disease, because its correct diagnosis and treatment will enable you to do a great deal to alleviate the sufferings of the patient. I would lay great stress upon this, because I am sure that there are a large number of wretched people suffering from atrophic rhinitis who are never properly treated, and who are unnecessarily doomed to lifelong misery, for, as you will see when we go over the symptoms together, it is a noisome disease, the troubles of the patient being thus greatly added to by the knowledge that he is offensive to his friends.

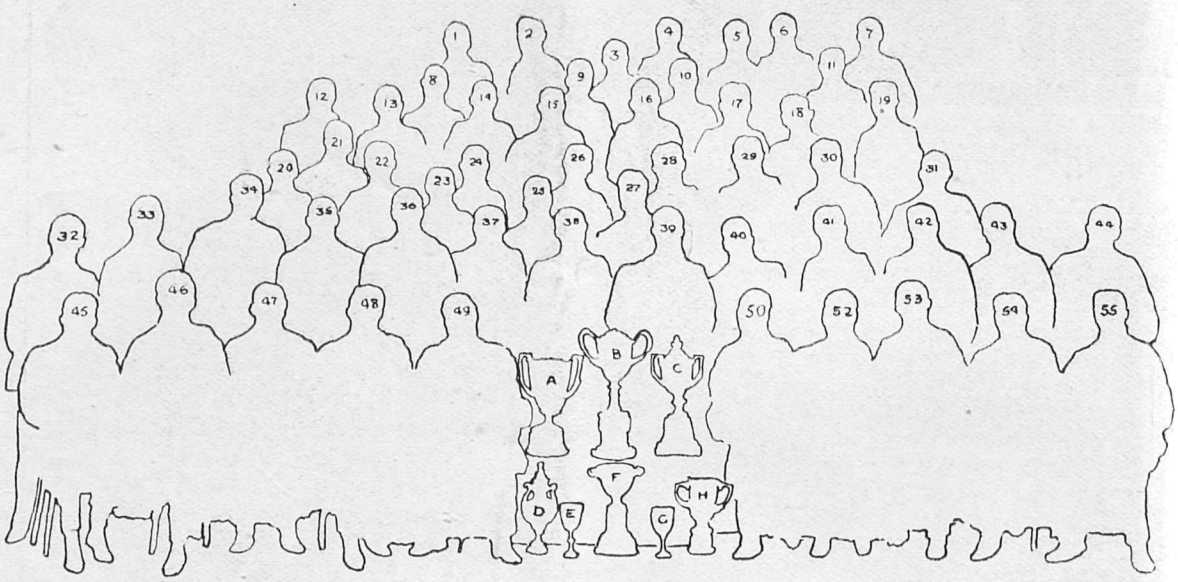
I will first touch upon the course, general pathology, and the changes which take place in the condition, because that will enable you to get a clear idea of the symptoms, and therefore of the treatment.

Now with regard to the *facial type*. People suffering from atrophic rhinitis will generally



Guy's Hospital Cup Teams. Winners of Inter-Hospital Cups, 1905.

(For Key Plan see over).



1. W. G. Pinching.
2. S. M. Saunders.
3. J. S. Cooper.
4. V. S. Houchin.
5. T. E. A. Carr.
6. R. J. Messent.
7. S. H. Barlow.
8. G. F. Allison.
9. F. P. Lowe.
10. A. G. Jones.
11. P. V. Pedrick.
12. R. Willan.
13. G. F. Greening.
14. H. H. Carter.
15. H. G. Gibson.
16. R. E. French.
17. F. Husbands.
18. E. L. Pilbeam.
19. H. Stott.
20. T. H. Edey.
21. F. Cutler.
22. S. A. Piper.
23. G. N. Bartlett.
24. L. G. Davies.
25. A. Zorab.
26. C. F. Fothergill.
27. A. D. Crofts.
28. E. N. Plummer.
29. J. S. Bookless.
30. G. A. Ticehurst.
31. G. Russell.
32. M. G. Louisson.
33. H. E. Turner.
34. E. A. Collins.
35. H. M. Langdale (*Capt. C.C.*)
36. A. L. Foster.
37. E. H. B. Milsom.
38. E. Morgan.
39. P. C. Litchfield.
40. A. F. Denning.
41. P. F. McEvedy.
42. A. R. Thompson.
43. F. Alcock.
44. G. C. F. Robinson.
45. F. Morres.
46. A. M. Tolhurst (*Capt. 2nd C.C.*)
47. E. M. Harrison.
48. A. B. O'Brien (*Capt. R.F.C.*)
49. W. A. Brailey, Esq., M.D. (*President C.C.*)
50. E. L. Norton (*Capt. A.F.C.*)
52. H. D. Wyatt.
53. H. Barber.
54. R. Felton.
55. A. Leeming (*Capt. 2nd A.F.C.*)

A. Shooting Cup (*Bisley*).
B. Cricket Cup.
C. Football (*Association*) Cup.
D. Cross-Country Cup.
E. Cricket (*2nd*) Cup.
F. Football (*Rugby*) Cup.
G. Football (*Association 2nd*) Cup.
H. Shooting (*Armitage*) Cup.

strike you as having a particularly broad nose, which, as a rule, is not at all prominent. The bridge of the nose is often depressed, as if the patient had lost a certain amount of bone from it; that is to say, the nasal bones, instead of standing out from the frontal bone, are flattened, so that the angle between the frontal and the nasal bones is a very obtuse one. Moreover, as the result of the broad, flattened appearance of the nose, the nostrils point forwards, and they often look dilated. I mention these points because the type is so utterly different to that of people who are the subjects of the opposite kind of rhinitis, *i.e.*, hypertrophic rhinitis, in which the nose tends to be large, prominent, and narrow.

With regard to the actual changes which atrophic rhinitis produces, let us look first at the changes in the nose. Those who suffer from the condition, usually have a wide nasal cavity, and the changes produced in the disease have the effect of increasing the size of the nasal cavity, or at least its capacity. You will remember that the mucous membrane of the nose is for the greater part covered with columnar, ciliated epithelium. In the mucous membrane and submucous tissue there are numerous glands, which secrete a large quantity of watery mucus, that is evaporated and helps to saturate the inspired air with aqueous vapour. Deeper still are the various bones, some, particularly the spongy bones, such as the inferior turbinated, containing in their irregularities a large amount of cavernous tissue, with big blood spaces, which may fill up and form large prominences in the nasal cavity. The first change is in the epithelium, so that in a person suffering from atrophic rhinitis you find that the epithelium is no longer ciliated; in other cases you will find that instead of it being columnar epithelium it is cubical, and in extreme cases the normal columnar ciliated epithelium is converted into squamous epithelium. But although these changes take place, you must bear in mind that the epithelium is never lost; there is no such thing in this condition as ulceration. The glands in the submucous tissue also undergo atrophy. In advanced cases there are practically no glands, the greater part of them having, in some mysterious manner, disappeared. The same applies to the cavernous tissue, for it also disappears, and finally the bone itself is gradually absorbed. In this way the nasal cavity becomes bigger and bigger, and in severe cases, on looking into the nose you can see no sign of any inferior turbinated body at all, so that you can look straight through the anterior nares into the naso-pharynx. In an extreme case then there is complete atrophy of practically all the structures.

With regard to the seat of the greatest amount of change, I have no hesitation in saying that the inferior terminated body is the part chiefly affected. Later in the disease you will find that the parts elsewhere, will be affected in the same way, and the atrophy may extend to the middle turbinate, or even high up into the ethmoid bone itself. The disease may also spread to the naso-pharynx, so that in advanced cases, the mucous membrane, instead of being thick and velvety, is thin, white, and glistening, and has a dry appearance, showing that atrophy has taken place in the epithelium and submucous tissue, and the glands contained in that tissue. We come next, by one step further, to the larynx, and there again the same change may take place. In some cases the larynx is dry and pale in colour, and sometimes, as I shall mention later on, you will find typical crusts adherent to various parts of the laryngeal mucous membrane. So that this peculiar unexplained atrophic process not only involves the nose, but may also affect the naso-pharynx and oro-pharynx, and occasionally the larynx itself.

I ought to say something about ætiology, but when I tell you that practically the disease is unexplained you will understand that there are innumerable theories advanced to account for its occurrence. None of these, however, are quite satisfactory. I will mention one or two of them. (1) Various observers have suggested that it is connected with nasal obstruction; it is supposed that conditions associated generally with nasal obstruction, and particularly the condition known as hypertrophic rhinitis, do eventually give place to an atrophic process leading to atrophic rhinitis. The idea of hypertrophy and infiltration, possibly with inflammatory products, being superseded by contraction and atrophy, is certainly suggestive; but I think there is very little to support it. Certainly, I have never seen any case, nor have I been able to find one recorded, of a patient suffering from atrophic rhinitis who had previously had obstruction of the nose, or difficulty in nasal breathing. But I think the most important point against this theory is, the facial type of the patient. People who suffer from obstruction and hypertrophy of the mucous membrane tend to have a narrow nose, and a prominent one, whereas those who suffer from atrophic rhinitis generally have a broad and flattened nose, and on looking into the nose it is seen that the nasal chamber is big quite apart from the atrophy. So there

is little to show that obstruction leads to atrophic rhinitis.

(2) The opposite view is held by many people, namely, that abnormal patency is causal; in other words, that the subjects of this condition begin life with a nasal cavity which is bigger than normal, and that for some reason it develops more rapidly than it should, so that its capacity is greater than the average. This, you can easily see, would result in a diminution of the force of the air passing through it. You may compare it to a stream of water; as the banks become further apart the rate of the current diminishes, and as they get nearer together, the rate increases. It is supposed that, owing to the diminished force of air in atrophic cases the mucus is not cleared away as it should be, but dries on the surface of the mucous membrane, then decomposition ensues on its under surface, with the result that atrophy is produced, the atrophy being explained, partly by infection of the under surface of the crusts, and partly by the contraction of the drying mucus itself, which is supposed to squeeze the mucous membrane and so produce anæmia, followed by atrophy. This certainly therefore explains the formation of the offensive crusts, although it does not account for the atrophy. The theory is moreover strongly supported by the fact that this crust-formation is frequently seen in conditions other than atrophic rhinitis, in which the size of the nasal cavity is excessive, *e.g.*, in cases where bone has been removed and has necrosed.

(3) Another theory is, that the cause is rhinitis, that is to say, that some form of simple catarrh probably starts the whole process, and that this, for some reason, becomes chronic. Then it is supposed that, possibly from some peculiarity already present in the nose, or from a decline in the general health, there is a persistence of this catarrh, which leads to atrophy. But it has not yet been explained why the atrophy should take place. At any rate, there is something in support of the view that the disease commences with rhinitis, because practically all the patients say it begins with a very bad cold.

(4) Lastly, as you would expect in these days of bacteriology, many people claim to have proved it to be a specific infective disease. Many have worked at the bacteriology of atrophic rhinitis, and with a great variety of results, showing that probably none of them can be accepted. I will, however, mention two: (1) The pseudo or attenuated, diphtheria bacillus has been isolated in many cases. Possibly atrophic rhinitis does result, in some of these cases at any rate, from nasal diphtheria. (2) There is another organism, the bacillus mucosus, which has been found in a large number of cases; but there is nothing to prove that the organism has anything to do with the causation of the disease. Everything goes to show that whatever organism may be found, it is more probably present as a result of the condition than a cause.

I do not think I will trouble you with any other views; those I have mentioned are the most important. The most likely explanation appears to me to be a combination of Nos. 2 and 3. Supposing that a delicate child with an abnormally patent nasal fossa, gets a bad cold, which is persistent, so that there is the constant presence of sticky mucus, it is conceivable that this mucus may, as a result of the insufficient force of the air current, dry on the surface of the mucous membrane and help to lead to contraction. The mucus may also become infected with organisms which produce decomposition, and that decomposition may in some way set up a further change, which may lead to atrophy. But the actual cause of the atrophy is not explained a bit. As I said at the commencement, there is nothing like it occurring in any other known disease; for the whole of the tissues tend simply to disappear without any ulceration or sign of inflammatory action whatever.

Having got a clear idea of the changes which occur, and of some of the possible causes, we can better consider the clinical aspects.

First, with regard to the *sex*. A large proportion of those who suffer from atrophic rhinitis are females. There is no explanation of that; but you must accept it as a fact. You will find collections of cases show about 80 per cent. females. As to *age*, it tends to begin in quite young people, generally at about the period of commencing sexual activity, from ten to sixteen years.

With regard to the general clinical characteristics, you will nearly always find that the mother will say that on a certain occasion the child got a very bad cold, which never seems to have cleared up, and that this was associated every now and then with the expulsion of masses of stinking discharge. I have already described the appearance of the patient. The next thing that strikes one is the *anæmia* which is nearly always present. The women who suffer from this condition are generally weak, flabby-looking creatures, but whether the anæmia is the cause or the result of the disease it is not easy to say. I think it is

likely to be a result rather than a cause. People who have decomposition going on in some part of the body might be expected to be absorbing small doses of toxine, which might easily lead to anæmia. A symptom which is always present is *ozæna*. Atrophic rhinitis is frequently called ozæna, but as the symptom does occur in other diseases besides atrophic rhinitis, it is much better to use the proper term. All that ozæna means is a stink coming from the nose. In this disease, owing to the atrophy of the olfactory mucous membrane, the patient does not smell it, which is certainly fortunate, though it is bad for his friends. Those who have smelt ozæna once will not be likely to forget it; it is a peculiar penetrating sweet odour, different from that which you find in syphilis, for instance. In bad cases you can notice the smell as soon as the patient enters the room.

Next the patient will tell you that she is constantly discharging large crusts from the nose. Sometimes these masses are an inch long, and greyish-green in colour, and they are clearly infected with some saprophytic organisms. Sometimes they come away every day, sometimes once or twice a week, sometimes only once in several weeks. I remember one instance where a woman said that she could clear her nose only once every six weeks, and that the process was attended with a good deal of pain. Sometimes the masses are so hard that they have been mistaken for sequestra; and dressers have taken away such masses in the Throat department and thought they had removed pieces of dead bone. Another symptom which troubles the patients is *dryness and heat* in the nose and naso-pharynx; and they may be constantly aware of an uncomfortable sensation at the back of the throat. If the disease has involved the naso-pharynx they will hawk some of the discharge down the back of the nose into the mouth, and possibly from spreading to the Eustachian tubes *deafness* may be a complication. The disease also tends to affect the laryngeal mucous membrane, so that the patients may suffer from *loss of voice*. Sometimes this occurs suddenly in the middle of a sentence, and after coughing and bringing up some dried mucus the voice is recovered for a time. On examining these patients you can occasionally see black or grey, dried crusts attached to some part of the mucous membrane; and when these get loosened they may become lodged on the vocal cords, and produce an attack of spasm and inability to speak for a moment. The reflex irritation arising from either the nose, the naso-pharynx, or the larynx, may lead to another symptom, namely, *asthma*. I have seen one instance in which a patient suffering from marked atrophic rhinitis had asthma; and as the result of treating her rhinitis I have reason to believe the asthma is improving, but it is only seven or eight weeks since I first saw her.

Now as to the *signs*, that is to say, the appearances on a rhinoscopic examination. It is always important in patients complaining of these and similar symptoms to make a rhinoscopic examination of the nose. As you would expect from what I have told you, the first thing you would see would be an accumulation of blackish, or greyish, or greenish masses; or you may think the nose is blocked by a foreign body; or that it has a sequestrum in it. You may verify these being crusts by loosening some of them with a little bicarbonate of soda solution on a piece of wool. This will dissolve a portion of the mucus and permit the mass to come away. Then if you examine after the removal of the crusts you will be struck by the large size of the nasal cavity.

In a normal nose you see a narrow chink by means of the speculum, but if you examine a patient suffering from atrophic rhinitis you will see the septum running backwards, and perhaps on the mucous membrane of the outer wall you may see a slight prominence, which represents the site of the inferior turbinated body, and there is a channel between big enough to put your finger in, so that you can see the naso-pharyngeal mucous membrane quite clearly. In case you are not certain as to whether you are looking at the posterior pharyngeal wall, all you need to do is to ask the patient to swallow, when during the process of deglutition you will note that the pharynx is raised up, and you can see the mucous membrane move up and down. If you see that, you will know you are looking at the naso-pharygeal mucous membrane, and that the inferior meatus is really big. There is no such condition as ulceration to be seen, no real pus, and no discharge of a yellow colour. Neither are there any areas of bare bone. These points are, of course, important in relation to diagnosis.

Let us now consider the chief conditions from which you have to diagnose atrophic rhinitis. First, I should put *syphilis*. Tertiary syphilis sometimes produces a condition in the nose which is easily mistaken for atrophic rhinitis; that is to say, a gummatous osteitis and periostitis may occur in various parts. Very likely the inferior turbinal, part of the ethmoid or part of the septum may be affected; and what happens is, that the periosteum or

muco-periosteum becomes infiltrated with small cells, which eventually caseate and break down, leading to ulceration, and through the ulceration the bone becomes infected and then necrosis occurs. If you examine the patient after this has taken place you notice that the nasal cavity is bigger than it should be. If you look into the nose when a piece of the dead bone is left, you may mistake it for crusts, just as crusts are often mistaken for dead bone. Again, as in atrophic rhinitis, the patients complain of getting crusts from the nose, and that complaint is made to them of the stench; they do not usually smell it themselves, because the destruction has involved the olfactory region. But the smell is different from that of atrophic rhinitis. Moreover, if you examine a patient who has had syphilitic necrosis you will find there is a definite loss of tissue, for instance, there may be a big hole through the nasal septum. You will know that that cannot be due to atrophic rhinitis, nor can sequestra if present.

Next we have to diagnose atrophic rhinitis from *sinus disease;* that is, suppuration of the antrum of Highmore, the anterior ethmoidal cells, the sphenoidal sinus, or the frontal sinus. If suppuration is taking place in any of these sinuses and there is not a very free discharge for the pus, as that pus works its way down it dries up and gives rise to crusts. There is a certain smell about the discharge, but on examining the nose and wiping away the crusts you will see liquid pus beneath, which is nearly always of a canary yellow colour. Again, in sinus disease the patient may tell you she blows down her nose liquid pus in addition to hard crusts.

Now I want to speak of the mucous membrane itself. In atrophic rhinitis the mucous membrane is atrophied; in sinus disease the effect of the irritating discharge over the rest of the mucous membrane, that is to say, that part which you can see, is to produce hypertrophy, which often takes the form of polypi. So that, if you see polypoid growths attached to the middle terminated body in association with pus you know you are not dealing with atrophic rhinitis, but that the patient has probably got sinus disease.

Next, I would mention *dry rhinitis*, which is often confused with atrophic rhinitis in the early stages. The patients complain of a sense of constant dryness in the nose; that they never have a watery discharge, but occasionally get hard bits down the nose. Dry rhinitis is a definite disease, and has nothing to do with atrophic rhinitis. You see that the mucous membrane is glazed and dry, and you may see a filmy layer of mucus, which is partly or completely dry, attached to different parts of the mucous membrane. Moreover, you may occasionally see that the inferior turbinated bodies are small; but that depends on the type of dry rhinitis you are dealing with. Dry rhinitis occurs in the course of general anæmia. Girls suffering from bad chlorosis sometimes have it. Probably the anæmia diminishes the fulness of the inferior turbinated bodies with the result that the nasal cavity is bigger than it would be in health. In men sometimes, chiefly alcoholic or gouty subjects, you also see a condition of dry rhinitis; but in them instead of the mucous membrane being pale and shrunken, the nose is red, sometimes even the skin outside, and sore, and there is a quantity of dried-up discharge all over those parts of the mucous membrane which you can see. If you treat the gout or stop the alcohol you will see a rapid improvement.

Perhaps one ought to mention one other form of ulceration. If there is a *tuberculous ulcer* in the nose there is a loss of substance, and at the same time you may find a dry crust over the surface. But the differentiation from atrophic rhinitis is easy, because when you remove the pus you cause bleeding, and you can see there is a definite ulcerated area; whereas ulceration is not associated with atrophic rhinitis.

With regard to *treatment*, atrophic rhinitis is said to be an incurable disease. It is incurable in this sense, that whatever you do it will not make the mucous membrane, and bone, and cavernous tissues grow again. But it is curable in the sense that if you treat it properly, and if the patient will take the necessary trouble, the symptoms disappear, and instead of having these crusts and ozæna, and dryness, she can be made perfectly comfortable.

I would lay stress, in the first place, on the general treatment. If the patient is anæmic, as she often is, treat that with iron and arsenic, and so forth; and if you can do anything else to bring about improvement in the general health, do so. If you find there is constipation or dyspepsia, do your best to relieve them.

As to local treatment, the first thing, obviously, is to keep the nose clean. It is clear that these crusts tend to aggravate the condition, so you must keep the mucous membrane clear of them, and then you will find the ozæna will also disappear. How can you best clear the mucous membrane in these cases? As a general rule, it is not very safe to order nasal syringes and douches, because if there is any nasal obstruction, you

may by this means increase the pressure in the naso-pharynx, and some of the discharge or the lotion may get into the middle ear and set up otitis. But in atrophic rhinitis there is so little danger of any obstruction that you are quite safe in using a douche, or a fairly powerful syringe, in order to keep the mucous membrane clean. I generally order an ordinary Higginson's syringe, fitted with a nasal tip. If this is used, the powerful stream will wash away all the crusts. If it is used frequently, as it should be, the crusts will never again attain any great size. It is important to use a lotion which has a specific gravity about the same as normal blood serum. If you use water, for instance, it causes smarting and pain afterwards. I usually order a lotion containing salt, bicarbonate of soda, and a small quantity of carbolic. The bicarbonate of soda helps to dissolve the mucus and loosen the crusts, the carbolic will help to remove the smell, and it also seems to stimulate the mucous membrane. We have, in the out-patient department, printed slips which give the patient directions to put one teaspoonful of salt, one teaspoonful of carbonate of soda (which they can always buy) and one tablespoonful of carbolic (1 in 20) to a pint of tepid water. That makes enough lotion, very cheaply, to give the nose a thorough douching. You must direct the patient to squirt it into the nose on one side, and allow it to wash round the naso-pharynx and out at the other nostril. The soft palate must for this purpose be pressed hard up against the posterior pharyngeal wall. That can be accomplished by keeping the mouth open, and the best plan is to make the patient breathe noisily with his mouth open. Once the mucous membrane has been got clean, this treatment will keep it so; but in some cases the nose may be so blocked up that it is necessary to remove the crusts yourself. The best plan is to take pledgets of wool soaked in bicarbonate of soda solution and dab them over; this will loosen the crusts, which can then be removed, and afterwards the patient can keep the mucous membrane clear, if the syringing is done regularly.

With regard to other methods of treatment, various stimulants can be applied, in bad cases, such as formaline, and Mandl's solution; the nose may be plugged with wool soaked in the latter, which can be left in for fifteen minutes. There are innumerable other applications advised, as you would expect in a disease which is really incurable.

Two other methods of treatment I might mention. One does seem to be of some use, and that is cupric electrolysis. It is painful, and so an anæsthetic is necessary. A constant current of ten to thirty ampéres is applied. One pole is a copper needle, and the other is of platinum. The copper needle is inserted into the inferior turbinated body, and the platinum pole is placed upon the palate or the septum. Then the current is passed for some minutes. In bad cases it is worth while to try this.

The other point is that it is occasionally useful to plug the nose, or partially plug it, for part of the day. It is a good thing to let the patient sleep with the plug in the nose. Apparently if you diminish the amount of air going through the nose, the crust formation is diminished and the patient made more comfortable.

I have not said anything about *prognosis* under a separate heading, but you will gather what it is. You cannot, of course, produce hypertrophy of the atrophied parts, but you can relieve the symptoms, and the symptoms seem to cease giving trouble after thirty-five or forty.

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Wednesday, February 17th and 24th, 1.30 p.m., Clinical Surgery, by Mr. Symonds.

Saturday, February 13th, 20th and 27th, 1 p.m., Clinical Medicine, by Dr. G. Newton Pitt and Sir Cooper Perry.

Monday, February 15th, 1.15 p.m., Lecture by Mr. Steward.

Monday, February 22nd, 1.15 p.m., Lecture by Mr. G. B. Smith.

Guy's Hospital Debating Society.

This Society held a most successful meeting in the College Smoking Room on Saturday, February 6th. Dr. Spriggs took the chair at 8 p.m. The proposition under discussion was "That Marriage is a bar to Success." Mr. Morton Palmer proposed, Mr. Edey seconded, while Mr. Stebbing opposed and Mr. Digby seconded his opposition. There took part in the debate Messrs. Nicholson, Goble, Palmer, jnr., May, Rowlands, Purdom, Edridge, Jones, Norton, Bentley, Mills, Snell, Black, Aubrey and Hamilton.

The motion was defeated by a majority of three, twenty-one voting with the noes and eighteen with the ayes.

R. EDRIDGE, } Hon. Secs. and
H. A. WATNEY, } Treasurers.

Hospital Types.

The Sister.

"Oh gin some fay the power would gie us,
To see oursels as ithers see us."

The most noticeable thing about this type is that she is superior. The Sister stands high above ordinary mortals. She has attained this giddy height by a long and difficult journey, which has cleansed her from all the usual imperfections and weaknesses of a woman and given her great knowledge and power. You feel, or ought to feel, in her presence, what a miserable worm you are. Any little knowledge that you may have thought you possessed, is as nothing compared to her limitless stores, and you thankfully receive the crumbs she may give you, in the shape of instructions as to the dressing of your cases, the hour at which you may visit the ward, and the hour at which you may *not* visit the wards. If you are grateful and humble she may graciously go further and teach you many very wonderful things about life in general, and the correct and orthodox way to face its difficulties; but you must never forget that it is a superior being who thus condescends, and her words of wisdom must not be criticized. It must also be remembered that things seen from a height appear very different from things seen on a lower level. You may sometimes think that the Sister is rather narrow-minded, that she is prejudiced, even you may think that she is absolutely wrong—in the line she takes up—but she cannot be judged by the ordinary rules, she is above them, she is a Sister, therefore she is right and you are wrong.

Of course it is very good for one's character to work with any one so much above one's own level, and one does learn so much; but it has its disadvantages. There are times when one feels that an ordinary woman would be an agreeable change. That she might understand things better. She might remember the days when she was only a nurse and did not think that all men were either knaves or fools; she might occasionally feel that on some subjects one knew a little more than she did, or at any rate had a right to an opinion of one's own. She might be able to own now and then that she was wrong, for being only a woman that would not matter, and there would be a certain joy in feeling that in some ways one was her superior and could teach her something, that even one could help her and work with her rather than under her. But this is only a dream, Utopian, and not to be in our time. We go on in the best of ways in the best of all possible hospitals, with our majestic blue robed sisters sailing on their stately way—far above the rules that govern our lives down below, beyond our feeble judgment, above our criticism, and we can only fold our hands and say, "Wonderful are the ways of Sisters, and not to be understood of any mere man," and we watch with sorrow the nurses we knew as quite nice people appear in their blue gowns, and crystallize into lofty perfection.

Dental News.

Resignation of Mr John Henry Badcock.

It is with regret we announce the resignation of Mr. J. H. Badcock, after twelve years' service in the Dental School of Guy's Hospital. Mr. Badcock was appointed assistant dental surgeon to Guy's in 1891, lecturer on operative dental surgery in 1893, and dental surgeon in 1895.

He came to Guy's with an excellent record, having gained prizes as a student both at the Royal Dental and Charing Cross Hospitals. His ability was early recognised at our Hospital by his being appointed lecturer on operative dental surgery within two years, and full dental surgeon within four years of his appointment of assistant dental surgeon.

Mr. Badcock showed an individuality and skill which marked him as possessing the elements of a successful teacher, and he was at all times desirous of following any line of practice that seemed capable of development.

As a single instance we may mention that he advocated and successfully adopted some years ago the immediate regulation of teeth, technically called "alveolotomy."

This method is now well known to dental surgeons, but we may state for the benefit of some of our readers that the operation of alveolotomy consists in forcing misplaced teeth into position, under an anæsthetic, and keeping them in the regular arch by means of ligatures or splints. The regulation of teeth had formerly been done solely by mechanical means, and it is still adopted as a legitimate and safe plan, albeit slow.

Mr. Badcock's lectures, extending over ten years, were keenly appreciated by his class, and the practical resource of the teacher asserted itself from the beginning to the end of his discourses.

He proved himself an able colleague, and a man of independent thought and action.

We understand Mr. Badcock has resigned his position at Guy's on account of the pressure of private practice, and we can only say that whilst we are sorry the Dental School is deprived of his services, we offer him on behalf of the staff and students our warmest thanks for his past assistance as dental surgeon and lecturer, and our best wishes for his future welfare.

Guy's Hospital Christian Union.

The following two meetings will be held in the Board Room over the Counting House, commencing at 5 p.m. and closing at 5.45 p.m.:—

February 25th. J. E. Reid, Esq., will give an address.

March 10th. General meeting and election of next year's officers.

Notices.

Royal College of Surgeons of England.

Syllabus of three lectures on "The After-Effects of Head Injuries," to be delivered in the Theatre of the College by Professor T. CRISP ENGLISH, F.R.C.S. (Hunterian Professor).

LECTURE I.—Monday, February 15th, at 5 p.m.

Introduction. Need for further advance in Cerebral Surgery.

Summary of 300 cases of Head-injury investigated at varying intervals after the injury.

General Results of Investigation.

The Effects of Head-injuries on the wage-earning capacity.

Traumatic Cephalalgia:

Varieties; causes: pathology.

Painful scars; vertigo; vomiting; disturbed sleep.

Mental Symptoms:—

Changes in disposition and character; depression; irritability; inability for mental and physical exertion.

Intolerance of alcohol, and high temperature.

LECTURE II.—Wednesday, February 17th, 5 p.m.

Aphasia; Amnesia; Agraphia; impairment of other faculties. Traumatic Somnambulism.

Lesions of Cranial Nerves; Nystagmus; Otitis media.

Glycosuria and other less common effects.

Pathology. Diagnosis. Medico-legal Aspects. Prognosis. Treatment;—

General management of cases.

Drugs.

Operative treatment.

LECTURE III.—Friday, February 19th, 5 p.m.

Late Traumatic Cerebral Abscess.

Traumatic Cephalhydrocele.

Traumatic Epilepsy.

Traumatic Insanity.

S. FORREST COWELL,
Secretary.

Chapel Notices.

PREACHERS in Lent at the special week-day services, 8.15 p.m.:—

Ash Wednesday, February 17th, The Bishop of Rochester.

Tuesday, February 23rd, Rev. S. Bickersteth, Vicar of Lewisham.

Wednesday, March 2nd, Rev. Canon Taylor.

Tuesday, March 8th, Rev. W. Wragge, Vicar of St. Anne's, South Lambeth.

Tuesday, March 15th, Rev. A. R. Kingdon.

Tuesday, March 22nd, Rev. H. Mosley, Rector of Poplar.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Guy's Hospital Debating Society.

DEAR SIR,—I am instructed by my Society to enquire, why the report of the debate, held on the evening of Saturday, December 12th, and sent in to yourself in ample time for publication on December 19th, did not appear in the GAZETTE of the latter date. The Clubs' Union Blue Book clearly points out that it is the duty of the GAZETTE to reproduce news from the various constituent societies, and the Debating Society feels that it has a right to demand and receive an explanation for this departure from the rules clearly indicated both by law and tradition. Trusting you will not take advantage of your position to evade an enquiry.—I am, yours sincerely,

RAY EDRIDGE (Hon. Sec. Debating Society).

Appointments.

Civil.

OUSTON, THOMAS GEORGE, F.R.C.S. Eng., L.R.C.P., has been appointed Medical Referee for the Morpeth and Blyth, North Shields, Newcastle, Gateshead, Hexham and Bellingham Districts in County Court Circuit No. 1.

SPON, H. J., M.R.C.S. Eng., L.R.C.P., D.P.H. Camb., has been appointed a lecturer on Hygiene and First Aid to the School Board for London Evening Continuation Schools.

Naval.

Surgeon SIDNEY CRONEEN, R.N., has been appointed to the *Excellent* for the *Hero*, and Surgeon ALFRED W. IREDELL, R.N., to the *Cornwallis*.

Papers by Guy's Men.

Acute Hæmorrhagic Pancreatitis: Operation: Recovery. By Charles Muspratt, M.D.—*British Medical Journal*, 6th February.

A Contribution to the After-history of Gastric Ulcer. By James W. Russell, M.A., M.D., M.R.C.P. Lond.—*The Lancet*, January 30th.

Clinical Urinary Analysis: A Critical Study. By Captain J. C. B. Statham, R.A.M.C.—*Journal of the Royal Army Medical Corps* for February.

On Common Diseases of the Liver. By W. Hale White, M.D., F.R.C.P.—*The Clinical Journal*, February 10th.

Officers' and Servants' Dinner.

THIS annual festive meeting took place at the Bridge House Hotel on Monday evening last. Mr. Bonsor presided, being supported by Mr. Hugh Colin Smith and General E. H. Clive, Governors, and many members of the Medical, Surgical, Dental and School Staffs. With the exception of Sir Cooper Perry, who was detained on other business, all the principal officials of the Hospital were present, together with strong contingents from their various departments. A company to the number of one hundred and fourteen sat down to a most excellent dinner, at the conclusion of which the chairman gave the usual loyal toasts, and an enjoyable entertainment followed. Amongst those who contributed to this were Mr. Alan Forty, Mr. Charles Conyers, Mr. F. J. Pittman, Mr. R. Felton, Mr. W. Fullerton, Mr. W. Baddeley, Mr. A. Hammond Smith, Mr. W. Reeve, Mr. M. S. Phi son, and Mr. L. Imeson. Where all were good, special mention may be made of the talented humour of Mr. Charles Conyers, which convulsed the entire audience and won for him new friends. The quartettes sung by Messrs. Felton, Forty, Hammond Smith, and Reeve, were also highly appreciated.

In proposing the toast "Prosperity to Guy's Hospital," Mr. Hugh Colin Smith, as an old Governor, and a gentleman having large local interests, had a pleasant task, which he concluded by wishing for the Hospital in its financial efforts similar success to that which attended its great services in the amelioration of suffering. The toast, having been drunk with enthusiasm, was responded to by the Chairman in a characteristic speech. General Clive gave the toast to the Medical School, paying a warm tribute to the work which Guy's men had done, and were doing in the world at large, and particularly in the Services. He referred with appreciation to the services rendered by Dr. Fawcett, the retiring Dean, and congratulated Dr. Eason on his new appointment. The Dean's reply was altogether charming in matter, tone, and delivery. His appeal to Guy's men to remember that they were little samples of Guy's Hospital all over the world, and that the reputation of the hospital was as much made by them as by the actual work done in the wards, made a great impression. Mr. Henry Williams proposed the toast of "The Visitors," to which Mr. Pittman responded, and then again, in the regrettable absence of the Hon. G. J. Goschen, M.P., Mr. Williams gave the health of the Chairman, to whom he paid that generous tribute which is Mr. Bonsor's due, in a speech which contained touching reference to his own forty-two years of continuous service in the Counting House. Mr. Bonsor, who met with a great reception, paid in return a high tribute to Mr. Williams, and thanked all at Guy's, whether associated with the Hospital or the Schools, for the loyal and consistent support which they had always accorded him in his capacity as Treasurer. An interesting and successful evening closed with the singing of "Auld Lang Syne."

The Present System of Treating Fractures.

A paper read before the Physical Society on January 30th, 1904, by Mr. P. A. PEALL.

MR. PRESIDENT AND GENTLEMEN,—When I undertook to give this paper on the "Present System of Treating Fractures," I decided to find out the difficulties encountered by dressers in their treatment of simple fractures. The point that struck me most was the fact that they did not know how soon they could commence passive movement of a limb in which the seat of fracture was situated near a joint. If they referred to a text-book they were greeted with the statement, "massage and passive movement should be commenced early." This interesting and concise statement I am afraid did not contain the required information. Not only did they not know when to commence passive movement and massage, but the method of application was also unknown. With your permission then, gentlemen, I will make "massage and passive movement" my first heading this evening. Perhaps some of those gentlemen who have lately become votaries of this science may be present to-night, and if so, I have one request to make of them, namely, that before criticising my statements they must bear in mind that the results I shall quote to them are those of dressers, who unfortunately have been unable to obtain their instruction from one of the gentler sex, having only nature as their guide.

Another point, which I thought would be interesting, was the comparison of the treatment of fractures by our various surgeons; but when one walked through Astley Cooper and Cornelius it was impossible to tell the colour of the card at the head of the bed by observing the splint applied to the injured limb. In only one main point did I find their treatment differing, and that was in the immediate application of a plaster of Paris splint in fractures of the leg. This subject I shall take as my second heading. At the present day, the ideal aimed at by every surgeon in the treatment of a fracture, is the restoration of the limb to its full functions with as little loss of time and as little deformity as possible, whilst at the same time exposing the patient to as little risk as possible. The great field opened to surgeons by the introduction of antisepsis, has, during the last decade or so, made some of them realise that many of the deformities following fractures could easily be obviated, if, soon after the accident, the fragments of bone were exposed and mechanically held in position. This mode of treatment I will discuss under my third heading. As my fourth and last heading I shall consider "the influence of the X-rays on the diagnosis and treatment of fractures."

MASSAGE AND EARLY PASSIVE MOVEMENT.

The use of massage and early movements in recent fractures originally introduced by Lucas-Championnière,

was first adopted in this country by Sir William Bennett. He pointed out that the treatment of fractures on classical lines did not fulfil that ideal which we have said ought to be the aim of surgeons. The old treatment of rigidly fixing the limb in splints till firm union had occurred, or in the case of the lower limb until the patient was able to bear his weight on the limb, was inevitably followed by stiffness and pain. The advantages derivable from shampooing and massage in sprains, wrenches and similar injuries have been recognised for centuries, especially as shown by the rapid removal of extravasated blood, the cure of œdema, the prevention of stiffness and the checking of muscle-waste, —the identical complications which may occur in simple fractures—and as after all a fracture is nothing more than an exaggerated form of sprain, the bone in addition to the soft parts having been torn, it is only common sense to apply the same form of treatment to a simple fracture. Of course the great objection raised against this plan of treatment is the belief that it is impossible to pursue it without producing movement between the fragments, and as the objectors maintain that movement, however slight, between the fragments is inimical to union, and therefore unsound, they naturally refuse to follow this plan of treatment. If, however, they thought for a short time, and considered the good union which occurs in simple fractures in lower animals, especially in the dog, and again, taking man, the union in fractured ribs, in both of which instances it is practically impossible to immobilise the bone, they must, if their minds are unbiassed, withdraw this objection. Another point worth noting and tending rather to prove that slight movement between the fragments of a broken bone promotes union by increasing the amount of callus produced, is the remarkable frequency of non-union in fractures of the skull, specimens of which can be seen in every museum, in which, of necessity, there has been absolute immobility. From these facts, I think, one can conclude that the slight amount of movement, if any, which occurs when ordinary care is taken in the application of this treatment, is not sufficient to interfere with sound union.

The advantages derived from massage are :—

1. The relief of pain.
2. The prevention of muscle-spasm.
3. The promotion of absorption of extravasated blood.
4. The prevention of muscle-waste.

To obtain the first two advantages massage should be started as soon as the fracture is set.

The contra-indications to massage are local conditions of the skin, from blistering or other causes.

How very often in treatment on the old lines, is a case of Pott's fracture seen, two or three months after firm union has occurred in the fibula, limping along, and his limp is put down to faulty position of the fragments. Now, gentlemen, in some cases faulty position may be the cause, especially if there has been rotation as well as displacement, but in the majority of cases it is due to adhesions between the muscles, fasciæ and periosteum around the seat of fracture. This matting together of the parts is prevented by early passive movements which consists of a gentle to-and-fro movement of the muscles about the fracture, and is well named internal massage. Besides preventing adhesions early passive movement—

1. Stimulates the circulation and therefore
2. Promotes rapid union.

Voluntary movement by the patient would be better than passive movement, as it not only prevents matting of the parts, but is a potent means of preventing muscle waste. This, however, is not safe until the fracture has become to some extent consolidated, but a combined passive and voluntary movement is most useful and can be practised earlier.

From what has been said of the advantages of this treatment it will be seen that the early application of massage and passive movement is a great aid to our ideal treatment, for if practised, by the time firm union has occurred, the limb is restored to its full movements and the stiffness, pain, and limitation of movement which practically always occurs when splints only are employed, and which can only be overcome by forcible breaking-down under an anæsthetic or prolonged perseverance on the part of the patient, are obviated.

The two fractures which the dresser finds himself most often called upon to treat are—

1. Pott's fracture.
2. Colles' fracture.

Pott's Fracture.—(i.) Immediately after the fracture is set, massage should be commenced. The flat of the palm of the right hand should grasp the limb smoothly, uniformly, but firmly, and smooth upward movement of the hand made. There should be no hesitation about grasping the limb, and you need not be in the least degree afraid of passing the hand over the fracture. This has a wonderful effect in soothing the patient, for it relieves pain and allays muscular spasm. Massage should be carried out daily. If the leg is put up on a back splint with side pieces, the latter should be removed: if a Croft is on the leg, the side pieces should be turned back.

(ii.) At the end of the second day, after ten minutes' smooth massage, passive movement of the toes "*en bloc*" is made. The hand is insinuated under the toes, which are then dorsi-flexed several times. This pulls upon the flexor tendons and produces a little movement in the muscles of the calf, by which up and down rubbing movement of the deep muscles in the calf adhesions are prevented from forming, and the circulation is stimulated.

(iii.) On the third or fourth day passive movement of the ankle may be commenced. The fracture is carefully steadied by the left hand, while the right hand grasps the foot and performs the movements. The ankle, of course, has to be freed from bandages, but the leg is still kept on the back splint with the strapping above the knee undisturbed. Three to five minutes should be devoted to passive movement at each sitting, but it should always be preceded by ten minutes' smooth rubbing.

(iv.) After a few days voluntary movements may be allowed while the fracture is steadied by the hand.

(v.) At the end of fourteen days the joint above the fracture is very carefully moved. The knee should be raised daily by degrees, until at the end of the third week the knee can be bent at right angles.

(vi.) At the end of the third week ordinary muscle massage can be carried out in order to develop the muscles throughout the limb. The splints can be left off entirely, and the patient got up on to a couch.

During the last few months five cases of Pott's fracture have been treated upon the above lines, and all of them have given good results, and in no case has any failure been experienced. The record case was William M., æt. 24, admitted into the hospital on October 13th, with the usual displacement. In the Front Surgery the leg was put up on a back splint with a foot-piece and two side splints, and the same evening a Croft's splint was applied. This patient had no pain whatever after the second day. In twenty-eight days there was perfect movement in the joint, and patient walked with the help of a stick, but without any splint. He commenced some light work seven weeks after the accident, and in nine weeks was doing his old work as a waterside labourer and carrying 1 cwt. and 1½ cwt. just as well as ever. When seen on January 25th the position of the fracture in the fibula could be felt, the movement in the ankle was perfect, there was no pain, and in every respect the injured leg was quite as good as the other.

In the four other cases the patients were able to walk in seven weeks without any support, and shortly after were able to do their ordinary work. One patient complained of a variable amount of swelling about the ankle after he had been at work all day, but this gave him very little trouble and soon subsided under the influence of massage. In this case it is only fair to state that on admission there was very great effusion into the joint, and crepitus was obtained over the internal malleolus.

Colles' Fracture.—In this fracture the first and most important step is the thorough reduction of the displacement, and if this cannot be easily effected—and often considerable force is required, especially if the fragments are impacted—an anæsthetic should be given. After ascertaining that the reduction is complete by comparing the relative levels of the styloid processes on the two sides, the forearm should be placed on a Carr's or a similar splint so that the splint is placed well behind the bases of the fingers.

Gentle, smooth rubbing should be used before the back splint is applied, and the patient should be told to flex and extend the fingers as much and as often as possible.

The smooth rubbing should be continued daily, and the back splint reapplied.

On the third day, gentle, passive movement of the wrist in a backward direction should be made while the arm lies on the anterior splint and after the smooth massage has been done.

On the fifth day the arm should be carefully lifted off the splint after the usual smooth massage, the fracture area being firmly grasped by one hand while the other hand gently flexes and extends the wrist a few times in succession. The whole process is repeated daily, and the movement gradually increased at each sitting.

At the end of a fortnight the patient may be allowed to take his splint off and move his arm freely of his own accord, while at the same time ordinary complete massage may be commenced.

All splints should be discarded at the end of three weeks, while the arm should be carried in a sling for another week only.

I have seen seven cases successfully treated in this manner and in which the movement at the end of three weeks was practically as good as in the sound limb. In no case has there been delay or mal-union.

The only real objection that I can see to massage and passive movement is the time that must be spent over the treatment, and I am sure that any dresser who is willing to look upon every fracture as a dressing and to devote fifteen minutes daily to treating them will be amply rewarded by the results he will obtain.

My next heading, gentlemen, is—

"The Immediate Treatment of Fracture of the Leg by Plaster of Paris Splints."

This method of treating fractures of the leg was first introduced by John Croft, and the splint which he employed bears his name. At St. Thomas's Hospital, from 1875—1880, there were 498 cases treated in this manner without any accident of any significance occurring.

The objections raised to this form of treatment are—

1. That if there is much swelling when the splint is first applied, the case may become too large for the limb when the swelling subsides, and may necessitate the further application of a second splint.

2. The risk of gangrene of the limb or of sloughing of the parts over the fracture from an increase of effusion beneath the unyielding case.

The first objection is a mechanical one, and is easily met by remembering that a Croft consists essentially of two lateral splints, and therefore by allowing more space between the lateral pieces when swelling is pronounced, after the effusion has been absorbed, all that is necessary is to bandage the splints more firmly together.

To obviate the second objection it should be made a rule to immediately open up the splint if any pressure symptoms are manifest; and of these symptoms the condition of the toes is the most reliable guide. Should they become livid in colour, or should there be tingling or numbness of them it must be taken as an indication to open the splint immediately. Great and steadily increasing pain referred to the seat of fracture also calls for the immediate opening of the splint and the relief of pressure.

In any case the splint should as a matter of course be cut up at the end of twenty-four hours, and rebandaged after the fracture has been inspected.

The advantages are numerous:—

1. The plaster material admits of the splints being accurately fitted to the inequalities of the leg and the plaster case takes its purchase from bony prominences. The fracture therefore is absolutely immobilised and there is no undue pressure anywhere.

2. The splint is extremely comfortable, and while the plaster is drying not only is a sense of cold produced, which is very agreeable to the patient, but the slight constriction which takes place tends to restrain the effusion.

3. The patient does not have to continue lying on his back, but is at liberty to turn on either side, and in a few days to get up on to a couch.

4. The materials can be obtained practically anywhere, the splint is extremely simple, and very quickly applied.

I am going to briefly describe the method of putting on a Croft.

A Croft consists essentially of two lateral splints moulded to the shape of the leg and fixed together by a starched muslin bandage. Each lateral piece consists of two layers of flannel so shaped as to be nearly equal in width to half the circumference of the limb at each point. The outer layer is stiffened by being impregnated with plaster of Paris.

The materials required are:—flannel, plaster (dried), starch, muslin bandages and strapping.

The following are the steps in the process—

1. The measurement of the leg and the cutting out of the flannel.

2. Soaking the muslin bandage in hot water and the mixing of the plaster in cold water.

3. Saturating the outer pieces of flannel with plaster and laying them out flat on the inner pieces.

4. Application of the splint to the leg; reduction of the deformity by extension on the foot and fixation of the splint by the bandages.

5. Drying of the splint.

The measurements necessary are:—

(*a.*) The length of the splint taken from the middle of the thigh along the anterior surface of the leg to a point just above the little toe.

(*b.*) Slightly less than half the circumference of the limb taken round the following points:—

1. The bulbs of the toes.
2. From a point in front of the ankle-joint—
   (*a.*) Round the point of the heel.
   (*b.*) Round the malleoli and tendo-Achilles.
3. Above the malleoli.
4. Below the swelling of the calf.
5. Round the largest part of the calf.
6, 7, 8. Immediately below, over the middle, and immediately above the knee.
9. Round the middle of the thigh.

The most important measurements are those round the ankle and the point which they are taken must be most carefully marked. In adjusting the splint care must be taken to fix this point first, for it is here that the front straight border of the splint turns forward at right angles to run along the dorsum of the foot, and if this point is not exactly adjusted all the other measurements will come wrong.

The next two stages must be done quickly, as five minutes only elapse from the time the plaster is fully mixed till it begins to set. Three men are necessary. One mixes the plaster and soaks the outer layers of flannel; the second lifts the latter out while the first runs his hands along them to remove any excess of plaster. They each lay one of the pieces on the inner layers, and taking hold of the two top and bottom ends apply them to the leg. The man taking the foot firmly fixes the important point at the ankle with his right hand while with the other hand he adjusts the foot piece, at the same time lifting the patient's foot from the bed. The third man stands ready with the muslin bandage and as soon as the splint is adjusted fixes it first above the malleolus and then round the foot, and then by figure of 8 turns round the ankle. As soon as the foot is fixed, the man who adjusted the splint to the foot is at liberty to make extension on the leg through the foot, which he must be careful to keep inverted and at right angles. The rest of the splint is then bandaged on. In applying the bandage, great caution should be observed that it is not drawn tightly anywhere and that no one turn of the bandage is tighter than another; in fact, the bandage should be rolled into the splint and no tension should be put on at all. Extension must be kept up while the plaster is hardening.

The practice of loosely stitching the two inside pieces of flannel together is of use in preventing the side pieces slipping down while the bandage is being applied. Every third stitch should be fixed by running the needle a second time through the flannel.

A narrow strip of strapping placed down the centre of the leg often prevents the patient being pricked with the scissors when the splint is cut up.

Many men have the conviction that a Croft is difficult and takes a long time to put on. It is perfectly simple, and all that is necessary is to see one put on. As to the time it takes, I can only tell you that while I was dressing, two of my colleagues turned out an excellent Croft in eighteen minutes from the time of entering to the time of leaving the ward.

The splint may be put on a limb when the latter is already swollen, red and blistered. Croft himself says, that so long as pulsation in the tibial arteries is natural, the splints may be applied. Blisters should be pricked and covered with dry gauze or boracic lint.

I must say that in my opinion, apart from operative treatment, the immediate application of a Croft's splint, combined with massage and early passive movement, is the best treatment for any simple fracture of the leg.

The five cases of Pott's fracture which I have quoted earlier, were all treated in this manner, and you could not wish for better results.

I will next consider the—

"Operative Treatment of Simple Fractures."

This method of treatment has been employed in two classes of recent fractures, namely, in those—

1. Near or involving joints.
2. In which perfect restitution of the bone to its original position is not attained by manipulations and the application of splints.

There can be no doubt that by exposing the fragments, placing them in accurate apposition, and connecting them, if necessary, with wire or screw, is the best treatment in these cases. The old objection to converting a simple fracture into a compound one cannot now be held when one sees the results obtained by so doing. But it must be remembered that it is practically only at a hospital or institution where asepsis, good nursing, and hygienic surroundings are obtained, that this form of treatment can hope to be successful, and even then there must always be some risk, for in some instances the state of the integument is such that it can ill resist the mechanical and chemical means necessary for perfect asepsis.

Of the first class of fractures, the ones most commonly seen at the hospital, are fractured patellæ and olecranons. Cases of transverse fracture of the patella, if treated by splints alone, can never walk about safely in much under a year, and then the union is only fibrous. If wired, the patient can walk in six weeks, and by this time the movement in the knee is practically normal. A case of transverse fracture of the patella with three-quarter inch separation was admitted under Mr. Symonds on November 13th. On the 18th the fragments were wired together, and at the end of the first week slight movement of the joint allowed. The muscles of the thigh were massaged for a few minutes daily. In five weeks the patient was walking about with the aid of a stick, and had fairly extensive movement of the knee-joint, and in eight weeks was walking quite as well as he ever did. When seen a few days ago the movement in the knee was perfect. The man said that he had had no trouble whatever since he commenced to walk, and that he was able to do his work as well as before. This patient earns his living by driving a two-horse van, which necessitates a good deal of climbing to reach his seat, so you can easily understand that the knee is often and severely tried.

For fractures of the olecranon, Mr. Lane says a screw is alone suitable; he has never been able to secure perfect apposition of the fragments by wire, but a screw driven into the base of the process secures perfect apposition and restores to the joint its original function. Care must be taken to embed the head of the screw, otherwise it may have to be removed months afterwards.

In fractures near or involving joints the advantages of securing apposition of the fragments with wire or screws are enormous. Not only can you restore the bone to its original continuity, wash away extravasated blood and see that no pieces of muscle or connective tissue are interposed between your fragments, but you have a force connecting your fragments which will stand a strain nearly as great as that which produced the original deformity, and which therefore allows extremely early passive movement without any fear of displacement—a most essential factor in the treatment of these conditions.

Cases of fracture through an epiphysial line, in which it is impossible by manipulation to restore the fragment to its normal position and to retain it there, should be promptly operated on, for in these fractures through a growing line the efforts at repair are extremely active, and very soon render it difficult if not impossible to separate the fragments from one another and to fit them accurately together.

For this class of fracture wiring has come as a great boon, for the considerable deformity, limitation of movement, loss of power and involvement of nerves, so often seen when these fractures are treated by splints alone are avoided by operative treatment.

Under the second class of cases in which wiring has been employed fall—

(i.) Oblique fractures of the tibia.
(ii.) Pott's fracture.

Fractures of the tibia produced by indirect violence are not only oblique, but very often spiral. In these spiral fractures external manipulation is unable to restore the bone to its original position, and this is the great argument in favour of wiring, for if this is not done, permanent deformity must follow.

In 1895–96 five cases of Pott's fracture were wired in this hospital by Mr. Lane. He found it impossible in every case, even with the patient under an anæsthetic, to reconstitute the fibula by manipulations of the foot. A lever and lion forceps had to be used to bring the ends of the fibula into apposition, and when this was effected the foot was at once restored to its normal form. Primary union was obtained in every case. I wrote to these five patients, but unfortunately only one turned up. This patient, a man 50 years of age, was extremely pleased with the result of his treatment. Since his operation he had never had any pain, and his foot has been in every respect as good as the other. The position of the fibula was perfect, and if it had not been for the presence of the wire, no old fracture would have been suspected.

The treatment of fractures by mechanical means is still in its infancy, and it seems to me that by this method alone can we hope to improve our present results.

My last heading, gentlemen, is—

The Influence of X-rays on the Diagnosis and Treatment of Fractures.

The introduction by Professor Röntgen of this method of examining has certainly conferred great advantages upon both surgeons and patients. By means of these rays a certain diagnosis can be made, especially when a doubtful fracture exists in the neighbourhood of a joint which is swollen and extremely painful when manipulated. An ordinary dislocation, which can be easily recognised and yet presents some unusual feature, when

examined with the fluorescent screen, may enable the surgeon to avoid a prolonged and useless effort at reduction by showing the presence of a complicating fracture.

In all cases of ? fracture ? sprain the rays are of value from the point of view of prognosis.

The direction of a fracture in relation to a joint can be observed, and the presence of any fissures or detached pieces of bone ascertained.

In fact, in exceptional cases of difficulty, this method of diagnosis is of permanent importance, for it saves the patient an infinite amount of pain and anxiety, and enables the surgeon to arrive at a definite diagnosis without too much manipulation. To set off against these great advantages there are several disadvantages, and of these the most serious is the facility with which a skiagram can be obtained at a hospital.

Men do not seem to realise that in a year or two they will be unable to give patients suffering from fractures, which they will be called upon to treat, a paper to come up at three o'clock to be skiagraphed. There is a growing tendency not to take the trouble to accurately examine and think over a case, but to accept the verdict of a skiagram without a question.

In taking a skiagram, the position of the limb should be carefully noted and the fracture looked at and skiagraphed from different aspects; for example, the neck of the femur may appear short or long, according to the degree of eversion of the limb.

Lastly, it must be remembered that it is only a shadow that we see and this shadow may be a gross exaggeration of the original deformity.

In conclusion, I wish to thank Mr. Wyatt and Mr. Williams for the keenness they have shown in carrying out the treatment which I have suggested earlier, and thereby obtaining many of the results which I have been able to put before you this evening.

Acute Cardiac Dilatation.

W. L., a painter, æt. 35, at work near the hospital, thought he would come up and get a bottle of medicine for his cough. While waiting in the surgery he was taken with urgent dyspnœa.

In the absence of any history, and after a not very complete examination, he was admitted as probably a case of some acute lung condition.

When admitted he was in great distress; there was orthopnœa, slight cyanosis, sweating, and semi-consciousness. The pulse was almost imperceptible, rate 110; the artery wall was thickened. The veins were not distended, the chest was markedly emphysematous, the apex beat could not be seen or felt, but pulsation could be felt in the epigastrium. Ordinary percussion did not reveal the size of the heart and the sounds were obscured by the emphysema and by numerous râles and rhonchi. There was slight œdema of the legs.

Strychnine, amyl. nitrite and oxygen were tried, but as there was no improvement at the end of ten minutes he was bled ʒxvi.

In less than an hour the acute symptoms had quite passed off and he was able to give an account of himself. Several years ago he had lead colic, but has had no other illness. A fortnight ago he began to have slight attacks of dyspnœa on exertion, but no pain. The attacks soon passed off if he rested. The present attack was quite sudden. He had never suffered from syphilis or rheumatism.

By auscultatory percussion the heart was found to be hypertrophied and dilated, extending as far as the anterior axillary line in the 5th and 6th spaces. The urine had s.g. 1012, albumen 1 in 1000, no casts. There was no lead line on the gums nor any optic neuritis.

Pulse tracings are notoriously misleading, but if the subjoined does not indicate high tension, the "flat top" shows a great want of elasticity in the artery wall.

The diagnosis made was arterio-sclerosis, due to chronic plumbism and acute cardiac dilatation, resulting from the consequent high arterial tension and degeneration of the myocardium. Up to a certain point improvement has been very rapid, the lung signs, œdema, and albuminuria clearing up in twenty-four hours; nevertheless the prognosis is considered very grave for the following reasons: 1. The pulse rate continues to be rapid although he has been confined to bed for three weeks. 2. The arteries are very degenerate for so young a man, and treatment does not materially lessen the blood pressure. 3. The heart is very little smaller than it was on admission. 4. The first heart sound is very short and resembles the second, the second sound is generally reduplicated at the impulse, and frequently the first is too, giving a quadruple rhythm, suggesting a degenerate myocardium and disturbance of equilibrium between the pulmonary and systemic blood pressures. 5. The emphysema further embarrasses the already overtaxed heart, and a bronchitis with the consequent cough would greatly add to his difficulties. In short, his heart is only just able to do its work under conditions of absolute rest.

A correct diagnosis is all important in these cases because so much good can be done by venesection, and it is very easy to make a mistake when the patient is very ill. Quite recently three such cases have been mistaken for some acute tuberculous process in the lungs. The presence of marked epigastric pulsation is a most important sign. Venous engorgement and cyanosis

are generally present, but both may be very slight, indeed some cases are said to be pale.

If emphysema obscures the size of the heart, the dulness may be made out by placing the stethoscope over the base of the heart and tapping with one finger over the precordial region. Beginning in the left axilla, a distinct rise in pitch is noticed when the heart becomes subjacent.

The pulse may be deceptive; generally it is rapid, but not always, and a thick artery or vaso-motor spasm may very easily give a wrong impression of the arterial tension.

The treatment is to relieve the cardiac engorgement at once. In slight cases amyl nitrite may do this effectively, but bleeding is generally necessary up to ʒxx, or even ʒxxx., and is especially effective in the emphysematous cases. Then when the heart has recovered from a condition approaching paralytic distension, cardiac stimulants, strychnine, digitalis and ammonia are useful. H. F. B. W.

Pass List.

Royal College of Physicians of London.

EXAMINATION FOR THE DIPLOMA OF MEMBERSHIP.

D. Forsyth, M.D.

Royal College of Surgeons of England, February, 1904.

(Unofficial.)

EXAMINATION FOR THE LICENCE IN DENTAL SURGERY.

PART I.—J. B. Ball, *S. H. Barlow, *H. S. Chandler, *W. E. A. Derriman, V. S. Houchin, *R. J. Messent, H. A. Pallant, *S. E. Pedler, *L. U. Ransford, H. E. H. Tracy, A. E. Williams.

*Denotes completion of examination.

Royal Army Medical Corps.

R. G. Anderson, S. C. Bowle, G. S. C. Hayes, T. C. Lucas.

Indian Medical Service.

H. Watts.

Final Conjoint Examination, January, 1904.

MEDICINE AND SURGERY.—*F. P. Hughes.

MEDICINE AND MIDWIFERY.—W. N. May, E. C. Myott, E. W. Routley.

MEDICINE.—G. Carlisle, *P. P. Cole, *C. M. L. Cowper, C. H. Denyer, *H. B. German, F. G. Goble, *M. G. Louisson, W. T. P. Meade-King, *C. M. Murray, *J. F. Rey, T. H. F. Roberts. *G. A. Ticehurst, *A. H. Turner,

SURGERY.—B. Moiser, *R. Moyle, G. H. Rees, C. S. Morris, *E. L. Ward.

MIDWIFERY.—F. Barnes. A. M. Benett, *J. B. Copland, M. Maher, W. S. Orton, J. D. Thomas.

*Denotes completion of examination.

Sport.

Football Fixtures.

SATURDAY, FEBRUARY 13TH.

G.H.R.F.C., I., v. Lennox, away.
II., v. Lennox II., home.
III., v. Lennox III., away.
G.H.A.F.C., I., v. Emeriti, away.
II., v. Surbiton Hill II., home.

THURSDAY, FEBRUARY 18TH.

Guy's v. University (Hospital Cup Tie).

SATURDAY, FEBRUARY 20TH.

G.H.R.F.C., I., v. Harlequins, home.
III., v. Catford Bridge III., away.
G.H.A.F.C., I., v. Kenley, away.
II., v. Clapham Rovers II., home.

WEDNESDAY, FEBRUARY 24TH.

G.H.R.F.C., II., v. Borough Road College, away.

SATURDAY, FEBRUARY 27TH.

G.H.R.F.C. I., v. Marlborough Nomads, home.
II., v. Old Merchant Taylors II., away.
III., v. Old Alleynians III., away.
G.H.A.F.C., I., v. Old Foresters, home.
II., v. Woodford Albion away.

Rugby Football.

Guy's v. Kensington.

This match was played on Saturday, February 6th.

Guy's kicked off against the wind and play settled in the Kensington half, they relieved with a good rush, but the Guy's forwards worked the ball back and from a scrum Cutler got the ball away, and it went right along the line, but Burney was well tackled by the full back. After the following scrum, the ball was passed along to the other wing and McEvedy got over, but in attempting to run round he was held up. After some loose play, a good bout of passing ended in Burney scoring. Harrison kicked the goal. After the kick out there was some more

loose play about half way, but the forwards did not heel well and Kensington got away several times. Harrison, McEvedy and Jones did some good tackling. After several scrums, a Kensington three-quarter intercepted well and they should have scored, but he was not well backed up. A good kick by Harrison gained a lot of ground and carried play into the Kensington half; then a really good piece of passing among our backs, especially Jones and McEvedy, let the latter in. The kick failed. After the kick out a free kick was given against us for off side, but a good run by Louisson relieved. Kensington then made a good rush and Guy's were forced to touch down just on half time. Guy's 8 points, Kensington nil.

Play re-started, Robinson putting in some good work on the line; we lost a good chance by waiting for the whistle. Then good passing by Guy's forced Kensington to touch down. The home side were getting posession of the ball, but could not profit by it; however, after some loose play, a Kensington three-quarter broke away, and kicking hard, followed up and gained a try. No goal resulted. McEvedy kicked off and Guy's carried the scrums and gained some ground. McEvedy made a good run and the whistle blew for no side, Kensington defending. Result, Guy's one gaol one try (eight points). Kensington one try (three points).

Guy's v. St. Bartholomew's.

INTER-HOSPITAL CUP TIE.—SECOND ROUND.

Played at Richmond, on Wednesday, February 10th. The ground was in very good condition, not at all wet until rain fell, about twenty minutes from the end.

Bart.'s kicked off from the road end; Morgan returned and, following up, collared the Bart.'s back on the twenty-five line. The Bart.'s forwards dribbled to our twenty-five, but were driven back by good kicking. The opposing forwards heeled the ball from the scrum, but their three-quarter passed badly, and only gained ground once, when McEvedy tackled their right wing near our twenty-five line. A free kick to Bart.'s for leg up in the scrum was well returned by Harrison to touch on the twenty-five flag. All our backs were making ground by good kicks to touch, and from a line-out on the twenty-five line Louisson passed to McEvedy who passed to Morgan. He ran behind the posts, and converted the try himself. A good kick by Louisson was returned to touch at half-way by Parkinson, who was playing well, doing a lot of saving work. A free to Bart.'s for off-side reached half-way. From a scrum Tolhurst and Pinching dribbled up to the backs; here they lost the ball, but Archer kicked away and scored far out. Morgan failed to convert. A round of passing among our backs ended in Morgan being collared at the twenty-five line. Our forwards were getting the ball from the scrum more often and the three-quarters were getting more chances. One of the Bart.'s forwards picked up and ran to the twenty-five where he was well collared by Louisson. Lee next ran through several of our men, but passed forward. Bart.'s continued to press, and were awarded a free for leg up on the twenty-five line. Jones returned well to half-way; our three-quarters next gained some ground and we were awarded a free kick. Bart.'s touched down. From a scrum on the twenty-five, Louisson passed to Jones, who dodged through the opposing three-quarters and then passed to McEvedy on the goal line; he scored far out, and Harrison failed. The Bart.'s forwards rushed the scrums, but Louisson, McEvedy and Jones saved well. Half-time—Guy's, 1 goal 2 tries; Bart.'s, nil.

Play became rather scrambling after half-time, but Guy's nearly always obtained the ball from the scrums. Orpen nearly scored twice after rounds of passing. Harrison was collared with the ball, but Louisson and McEvedy relieved with kicks to touch. Both lots of forwards went in for rushing, and play settled at half-way. Morgan ran to the twenty-five, and from the following scrum received from Louisson and scored far out. Harrison made a good attempt, but just failed to convert. Rain fell after this, and the ball became very greasy. Louisson started some more passing, and Morgan passed back to McEvedy on the line; he ran round behind the posts, but Tolhurst failed. Some free kicks to both sides were taken, but were not improved on. Saunders, who was often not in the scrum, dribbled to the twenty-five, and Bart.'s retaliated with a good kick to half-way. Here McEvedy picked up, handed off two three-quarters and passed to Morgan, who scored from half-way. He again failed with the kick. The Bart.'s forwards then dribbled to Harrison in our twenty-five; he picked up at their feet and ran a little, then he passed to Morgan, who ran through nearly the whole team and scored between the posts, McEvedy goaling. After this McEvedy picked up at half-way, and dodged through to the back; here he passed to Tolhurst, who scored between the posts, McEvedy again goaling. Soon after this, time was called. Guy's, 3 goals 5 tries (30 points); Bart.'s, nil.

The forwards played much better and got the ball from the scrum cleaner than usual. Saunders was good in the loose, but winged badly. Archer, Pinching, Earle and Mullins were good. Louisson played splendidly, both in attacks and defence. Cutler was poor in defence. Jones was very good in the first half, but not so good in the second half in attack. McEvedy and Morgan were too good, the latter could do nothing wrong. Harrison kicked and saved very well.

Association Football.

Guy's v. St. Bartholomew's.

CUP TIE.

This match was played at Winchmore Hill on February 2nd, and resulted in a win for Guy's, the score being 3—nil. Of course the ground was not in a fit state

for anything but boating, but as both teams were willing to turn out, it was decided to play.

Guy's won the toss and elected to defend the goal at the further end of the ground. The opposing forwards kicked off and made a determined rush, but Wilson cleared well. For the throw-in, our right wing got possession and made a most useful sprint down the touch-line, but sent behind. A few minutes of mid-field play followed, and then our inside forwards got possession. By some very clever passing the opposing defence was outmanœuvred, and Barber making no mistake, we had one goal to our credit.

Bart's were fairly on their mettle now. Do what they would, our forwards could not get within scoring distance. In fact there was hardly a pin to choose between the play of the two sides, especially as regards defence. Considering the state of the ground, the pace was positively furious. On two or three occasions our front line got within shooting distance, but the opposing custodian seemed to cover the whole goal-mouth and made some brilliant saves. In the meantime Bart's forwards had not been idle, the left wing in particular, being most aggressive and Collins was called upon to handle more than once. Half time was called, with Guy's leading 1—nil.

After the re-start we pressed almost immediately, and Barber sent in a shot which ought to have scored, but the goal-keeper just managed to turn it aside. Nothing came of the corner, the ball being sent behind. For the goal kick, Bart's forwards got possession, and by a judicious pass, the inside right was given a grand opportunity of equalising, but sent wide. From the goal kick we got possession, Deming passing to Plummer who raced away, and when confronted, passed out to Piper, who centred in great style. Barber captured the ball, but shot straight at the goal-keeper. A scramble followed, from which we scored another goal. Two goals up and twenty minutes to go. Up and down the field, with hardly a pause, went the game, and the enthusiastic spectators, ten in number, cheered wildly. Then came an anxious time for us. The opposing left inside got possession, dribbled past our defence, and at ten yards, with an open goal before him, sent wide. Soon the ball was in play again, and after some midfield exchanges, Wragg got possession and centred finely. Litchfield pounced on the ball and beat the goal-keeper, thus scoring the last goal of the match, which ended in a few minutes.

There was not much to pick between the play of the two teams, except in the all important point of shooting If our forwards can repeat the form they showed, he cup need not be moved from its snug berth for another year at least.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Change of Address.

Dr. J. Martin Bickerton, from Guy's Hospital to 6, Shaw Street, Liverpool.

Mr. T. Vernon, L.D.S., from Guy's Hospital to Glen Lyn, 55, Elm Grove, Southsea.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Calendar.

February, 1904.

Sat. 13.—Physical Society's Meeting at 8 p.m. Pathological Meeting.
Dental Society's Dinner at 6.30 p.m.
Messrs. Golding-Bird and Dunn's take-in; Drs., G. F. Greening and R. D. Barron: Cl., E. H. B. Milsom.

Thur. 18.—Mr. Jacobson and Sir Alfred Fripp's take-in: Drs., V. A. P. Costobadie and M. de L. Robinson: Cl., H. F. B. Walker.

Thur. 25.—Messrs. Symond and Steward's take-in: Drs., R. E. French and F. D. Crew; Cl., A. M. Webber.

Thur. 25.—Revision Classes for L.D.S. Eng., begin.

Sat. 27.—Physical Society's Meeting at 8 p.m. Paper on "The Diagnosis and Treatment of Coma," by N. 1. Spriggs.

Birth.

BARTHOLOMEW.—On January 9th, at the Croft, 31, West Hill, Wandsworth, the wife of Alfred Aldam Bartholomew, L.R.C.P., &c., of a son.

Marriage.

PRENTIS—DISMORR.—On January 21st, at St. Swithin's Church, Hither Green, S.E., by the Rev. Jessop Teague, B.A., vicar of Exminster, Devon, assisted by Rev. T. Roberts, M.A., vicar of St. Swithin's, John Edward Prentis to Evelyn May Stuart, eldest daughter of Henry Dismorr, Esq., M.R.C.S., L.S.A., and Mrs. Dismorr, of "St. Kilda," Lewisham Park.

Deaths.

DOLMAN.—On February 5th, at the Dispensary, Lincoln, Arthur James Dolman, L.R.C.P. Lond., M.R.C.S., aged 31.

HODSON.—On January 17th, at Hornsea, Hull, Frederic Hodson, M.R.C.S. Eng., L.S.A.

WITHECOMBE.—On February 1st, at Richmond, Surrey, John Rees Withecombe, M.D., F.R.C.S., Bengal Army (retired), aged 87.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 413.] FEBRUARY 27, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	81–83
Acute Hæmorrhagic Pancreatitis. Clinical lecture by Dr. J. Fawcett	84–89
Guy's Hospital Dental Society...	90
Notes from Skin Outers...	89–90
Physical Society	90
Acute Nephritis after Measles	91
Pass List	91
Artificial Feeding of a Premature Infant in the Incubator	92
Case of Henock's Purpura	92–93
The Residents' Annual Dinner	93
Appointments	93
Letters to my Son	94
Nurses' Choral Society and Students' Glee Club	95
Notices	95
Dental Society's Dinner	96
"Judge Not"	97
Reviews	97–98
Nursing News	98
Sport	98–100

Passim.

MOST Guy's men will have read in the medical journals last week of the serious illness of our Senior Consulting Physician, Sir Samuel Wilks. Taken somewhat suddenly ill on Friday, February 5th, the symptoms of acute appendicitis were soon marked. Dr. Pye-Smith saw him with Dr. Boulting, and on the sixth day Mr. Symonds was asked to operate, as there was an increasing swelling, and signs of general infection, though the temperature and pulse were low. A very foul abscess was opened and a gangrenous appendix containing a concretion was removed. For the first two days his condition was very anxious. Then he improved in all respects, and for a week everything was going well. On Sunday last, however, he showed great feebleness, which increased on the Monday and Tuesday, and great fears were entertained that his strength would not sustain the strain of the illness. On Thursday, when this report was handed to us, he showed a little improvement, and had taken more food, but his condition was still one of very great anxiety. His friend, Dr. Boulting, had unfortunately to relinquish his attendance, being himself attacked with the same malady. Mr. Porter-Wornum, of Hampstead, whom many will remember, is now taking charge of Sir Samuel.

THE news of Sir Samuel's illness has naturally caused the gravest uneasiness amongst the veteran governor's wide circle of friends. The GAZETTE, in particular, owes much to Sir Samuel's support in the past, for no member of the staff has contributed so much at different times to these columns. When last in the Treasurer's office he was himself commenting upon the fashionableness of an appendicular abscess, and it is a curious thing that he should so soon furnish another case in point. A more favourable bulletin than the above note will be read with the deepest thankfulness by all Guy's men.

THE Residents' Dance has come and gone, and the rooms on the ground floor of the Superintendent's house remain intact. This is not a vulgar gibe at the expense of the dancers, but has reference to certain wild rumours which were circulated amongst the more timid spirits previous to the occasion, to the effect that the Court Room had been condemned as unsafe for the purposes of a ball-room. The dance was a most enjoyable one and everybody was pleased. The gossip indulged in after these events is like unto no other, and the stories which were floating about for the few days following the dance would interest all not immediately concerned. Energetic members of the staff and the reverse;

gentlemen who feared to steer out into the open but hugged the wall lest they should be run down by larger craft; impossible people who dance excellently, and their converse who cannot unfortunately dance—these, and many others, were the wonders harped upon for nine days. The Residents are to be thoroughly congratulated upon the success of this annual function.

THE Dental Society's Dinner at the Trocadero Restaurant was as successful this year, from a general point of view, as it ever has been. That is to say the attendance was good, the dinner was good, and the entertainment was good, and what more could be said. This society has the reputation for giving the most sumptuous banquets, and the number of old dental men who come up from the provinces on these occasions is really remarkable. The same old jests were cracked at the expense of the representatives of the Examining Board, who from year to year are present as guests at the staff table. After-dinner speaking has become quite simple now that speakers really realise that not only have they the sympathy of their audience, but also their audience knows perfectly well what will be said by the speaker.

GREAT preparations are being made for the Smoking Concert, to be held on March 12th in the College Dining Hall, and it is already a matter for doubt whether the seating capacity of the room may not prove too small for the demands likely to be made upon it. The usual arrangement on these occasions will have to be improved upon, if the expectations of the stewards are fulfilled as regards attendance. The first part of the programme will not only be representative, but also novel, for one or two new performers are to make their débuts. As regards the play, which will occupy the whole of the second act, its authorship remains an impenetrable mystery, but it strongly suggests both Ibsen and Pinero, when it does not remind one of the "Surrey" at its worst. Every possible melodramatic character is here portrayed with the exception only of "Sally-generally-in-drink." The performance promises to be Elizabethan in its simplicity—in fact scenery is conspicuous by its absence—and every effort of the company is being directed towards dispensing with artifice, that art may be still further served. No advance is being made on the ordinary price of the tickets, to wit, one shilling, and those intending to be present should secure seats early or they may be disappointed.

IN consequence of the Smoking Concert, the last meeting of the Physical Society, due on the same date, has been postponed to Saturday, March 19th. At this meeting the Treasurer's Prize Essay on "The Uses of Electricity and Light in Surgery," is to be read. Competing essays should be sent in to one or other of the secretaries of the society either on or before March 7th.

IT is to be hoped that the Annual Ladies' Night of the Debating Society, which is to take place next Saturday, March 5th, in the College Smoking Room, will be at least as successful a gathering as was its predecessor of last year. The subject chosen for debate, "That the modern novel is decadent and has a pernicious effect upon Society," should prove most attractive to the ladies, for it is certainly they who are most largely concerned in the welfare of the novel, and it is therefore to be hoped that the question, as to whether or no the gentler sex are perniciously affected by the same, will derive an additional interest from the presence of a large number of fair disclaimers. The society's president, Dr. Savage, will occupy the chair, and it is confidently expected that a strong contingent of the junior staff and those interested in their welfare will be present as heretofore. The Debating Society, perhaps more than any other, has seen vicissitudes of fortune. In fact, it would appear to be a case of concomitant variation of success between it and the Physical Society, for when the latter is prosperous the star of the more general debate is temporarily on the wane, and *vice versâ*. The historic duties of Aaron and Hur of upholding the patriarchal hands that Amalek might not prevail, thus find a parallel in the respective duties of the secretaries of the two societies. The competition, though unconscious, is certainly real, and is probably

to the benefit of both parties concerned. It remains then for as many men as possible to attend the debate on March 5th, and also, if possible and permissible, to bring, or to be brought by, their respective ladies. The Ladies' Nights of the Society have always been well attended and highly interesting from every point of view, and the coming occasion will, we are sure, be no exception to this rule.

The number of entries for the course of instruction in massage has reached its limit, and Mr. Ormond regrets that there is no room for any further names at present. Notices of a fresh course will be duly given some weeks in advance.

The ultimate title of the new ward, although withheld still on the knees of the gods, is like most of the doings of these latter, being discussed by mortals, and the result has been the suggestion of many possible titles, and some sufficiently scandalous and impossible. Amongst those that are suitable for drawing-room consumption perhaps the name "Noah or Nod" will commend itself to many. The suggestion emanates from a highly respectable west-end practitioner, who, although not officially connected with Guy's, still retains a more than affectionate regard for the scene of his own past triumphs. It seems to be expected on all sides that the coming name is to savour of the Scriptural, and seeing that in that case it will not be musically sounding to modern ears, perhaps it would be found possible to make it still uglier by adopting this double-barrelled suggestion. Of course, if this name is analysed it is not really appropriate, for though Noah was the first recorded drunkard, Nod refers to healthy sleep and not to the sleep of death. Inappropriateness is no bar to its adoption as the name of the new ward, witness for instance "Lazarus," whose inmates are not all dead, or even doomed to death, nor will they escape the consequence of dissolution. This is of course but one example of many. Probably the alliterative aspect of the title "Noah, or Nod" is its chief claim to consideration.

This is mere flippancy, however, and we would reiterate the original suggestion made in our columns that the name "Samaritan" is at least as good as any that could be suggested.

The final round of the Inter-Hospital Rugby Cup-tie is to be played at Richmond on March 9th, when our team is to defend the Cup from the London Hospital. The semi-final contest with University proved a veritable walk-over for us, but the coming final will probably be a very different affair. It is hardly necessary to express the hope that as many men as possible will be on the ground to cheer the team on to another victory. On occasions such as these, the number of those on duty in the medical and surgical wards should be an irreducible minimum, and most other occupations, however absorbing, should be allowed to look after themselves. It is a well-known fact that it takes a large crowd to "assist" in bringing home the Cup.

Members of our 1st XV. have been honoured in various ways during the present season, but yet another tribute has been paid them. Messrs. O'Brien, McEvedy, Harrison, Morgan, and Saunders, have been asked to swell the ranks of the English team which sails for New South Wales on May 13th. We may congratulate all these gentlemen individually, and Guy's in general, at this further mark of esteem paid us in high sporting circles.

It is to be hoped that the representatives of hospital sport in every department will do the thing thoroughly this year. Not only are the Rugby and Association Cups to be defended, but there are Cups to be gained in the Inter-Hospital Boxing and Gymnastic contests which will have been decided by the time this appears in print, not to mention the other trophies of last year at present in our Smoking Room which will have to be competed for again. An ideal result would be an athletic photograph on a still larger scale with all these prizes safe for another year.

We are sorry to have to record the death of Mr. Wade, the College caterer. During his term of office the inmates of the College were well served in every respect, and by his death they are the losers of a valuable servant. We take this opportunity of voicing the general feeling of sympathy for his relatives.

Acute Haemorrhagic Pancreatitis.

A CLINICAL LECTURE BY Dr. J. FAWCETT.
May 6th, 1903.

Gentlemen,—The case I propose to bring before you to-day is one of a woman, æt. 36, who was admitted into Miriam ward, on April 15th last, for abdominal pain, associated with vomiting, and other symptoms. For the report of the case I am indebted to my "clinical," Mr. Wedd.

The history of the case is as follows:—The patient was suddenly seized with "chilliness" and pain in the abdomen on Friday, April 10th. Feeling very ill she took some brandy, but at once vomited it. The pain continued during the next day, and she remained in bed, but on the day following (April 12th) she got up, although she was still feeling ill and the pain had continued. On Monday, April 13th, she fell downstairs, and that evening the pain became very severe and vomiting recurred. On April 14th a doctor was called in; morphia was administered and two enemas given, but without any result. The bowels were last opened on the evening of April 13th; the pain and vomiting continued from April 13th until admission.

Previous history.—The patient stated that she had always been a very healthy woman, and could remember no previous illness; she had never suffered from indigestion, nor had she had any previous attack of abdominal pain; the action of the bowels and the menstrual periods had always been regular.

Condition on admission.—P. 160; T. 100.4°; R. 24. The patient was very ill and in great pain, the pain being especially marked on taking a deep breath. The pain was referred to the upper part of the abdomen, and especially to the right side. The abdomen was somewhat distended, and rather more prominent in the right hypochondriac region than elsewhere, and movement was deficient. On palpation the abdomen was very tender and rigid, mostly so in the upper part and on the right side, but there was some general tenderness. The note was resonant all over, and percussion did not seem to cause her great pain, although she was so tender on palpation. Liver dulness present. The breathing was shallow, and at the right base the entry of air was deficient, and a doubtful pleuritic rub was heard. Rectal and vaginal examinations were negative.

The patient was seen by Mr. Dunn, in consultation with Dr. Bryant, at twelve midnight with the view to an exploratory operation, but owing to her serious condition it was thought advisable to administer stimulants and saline fluid and wait. Next morning, April 16th, the patient's general condition was somewhat improved, although the local signs were much the same. The abdomen was then markedly distended, rigid and very tender, and most so in the upper half, as before. The pleuritic rub on the right side was more distinct, and during the night the patient had vomited some foul, dark brown fluid.

Thus, we were dealing here with a patient who had been taken acutely ill six days before admission to the hospital, and who on admission presented the signs and symptoms of an acute peritonitis affecting the upper part of the abdomen, but the cause of it was not clear. Several possibilities were discussed, but the correct diagnosis was not arrived at. I came to the conclusion that it was probably a case of gastric ulcer, which had perforated, and through which a gradual leakage had taken place, and led to a localised peritonitis. There had been no previous attack of biliary colic; there was no jaundice, *i.e.*, there was nothing suggestive of any infective condition of the bile ducts or gall bladder which could have led to this localised acute peritonitis. No tumour was to be felt, nor were there any signs or symptoms suggestive of the condition having started around the appendix cæci, or in the pelvis. The menstrual periods had been regular, and there had been no intervening hæmorrhages. Previous to the onset of this attack the patient had been in good health.

When the patient was first admitted it was thought that the condition might be a primary "thoracic" one, owing to the deficient air entry at the right base, and the presence of a pleuritic rub in that region, but the next day, although the rub was more marked on the right side, the signs so distinctly pointed to the lesion being in the abdomen that the question of its pleural origin was discarded.

In this connection I might draw your attention to the ratio of the pulse rate to the respiration. In a primary lung affection you generally find the respiration rate raised as compared with the pulse rate, but it was not so in this case. If you take the records of the temperature chart, which I have here, you will see that when the patient came in, the pulse was 124 and the respirations only 24. The next time the pulse was 140 and respiration rate the same. On another occasion it was 132 and

respiration rate again 24. These facts, in conjunction with the signs being more marked in the upper part of the abdomen, pointed to the primary lesion being in the abdomen. It is an important point for you to remember, because in such cases as these you may be in considerable doubt whether the pain in the abdomen is a reflected pain due to an acute intrathoracic lesion or not. As an example I may refer you to a clinical lecture I gave about eighteen months ago, in which the case of a patient was referred to who was admitted with severe abdominal pain and collapse, and who was thought at first to be suffering from a perforated gastric ulcer. For some reason operation was deferred, and the next morning the man was found to have well-marked signs of lobar pneumonia at the right base, from which he recovered.

Mr. Fripp operated upon our patient at midday on April 16th, and on opening the abdomen he found general and quite recent peritonitis in the lower part, and a little blood-stained fluid escaped. In the upper part of the abdomen there were recent well-formed adhesions, of older date than the peritonitis below. Small whitish-yellow areas of fat necrosis were seen in the mesentery and omentum.

On separating the adhesions in the upper part of the abdomen a large quantity of blood-stained fluid escaped, some of it brownish, some still brighter red. This fluid was chiefly contained in the lesser sac of the omentum. On opening this space more freely, numerous areas of fat necrosis were visible, especially over the head of the pancreas. The head of the pancreas felt enlarged, but no pus could be found anywhere, nor could we see any hæmorrhages into the tissues or organs in the neighbourhood.

The stomach and gall bladder were healthy, as were also the duodenum, the region of the appendix, and the pelvic viscera.

It was now quite clear that we were dealing with a case of acute pancreatitis. The disease is a rare one, and although, chiefly owing to the work of Reginald Fitz, we recognise it as a pathological entity, yet we are still very much in the dark as to the signs by which we can recognise this disease during life. Most of the cases seem to have differed in some way from those of a perforation, on the one hand, or of acute intestinal obstruction on the other. If, therefore, the history, the signs and symptoms point to a local peritonitis, but, at the same time, are of such a character as not quite to coincide with the more common causes of these conditions, then we must bear in mind the possibility of acute pancreatitis being present.

I will now shortly detail to you the notes of some cases which have been in the hospital, and which in connection with the case before us to-day, form a rather instructive series.

(1.) E.R., a female, æt. 33, was admitted, under Dr. Washbourn, on July 14th, 1901. She had been suddenly seized with severe pain in the upper part of the abdomen. She was sick shortly afterwards, and after two or three attacks of vomiting brought up half a teacupful of blood. She had never had an attack of this kind before.

On admission.—(4 p.m.). She was described as being a very stout person, lying in bed groaning, with the knees drawn up, and apparently in considerable pain. There was no "abdominal look" about her, and her pulse was only 70 per minute. The abdominal movements were deficient, and palpation caused considerable pain. At 9.30 p.m. I saw her, and diagnosed perforated gastric ulcer. At the operation, dark, altered, fluid blood was found in the peritoneal cavity, the mesentery contained extravasated blood, but no other lesion was detected.

Autopsy.—Fat necrosis was present, with hæmorrhages into the sub-peritoneal fat, especially into that of the great omentum. Blood was extravasated round and into the head of the pancreas and around its tail, into the omentum, the retro-peritoneal tissue, the broad ligament, and the wall of the duodenum. There were a few gall-stones in the gall bladder.

(2.) The next case was that of a female, E.G., æt. 55, who was admitted under Dr. Goodhart in March, 1898. The patient was very stout, and had suffered from indigestion for some time. At 10 a.m. on March 11th she was seized with severe abdominal pain, which continued until the evening. She was sick subsequent to taking some medicine in the morning, but not afterwards.

On admission.—Her temperature was 98°, and pulse 104. She is described as having been in great pain, which had persisted for fifteen hours. The pain was generally diffused over the abdomen, the latter being tender all over, but not rigid. Her general condition was good, and there were no signs of collapse, the only bad feature being the rapid pulse. Apparently no diagnosis was made in this case, but forty-eight hours after the onset an exploratory operation was performed. A quantity of blood-stained fluid welled up on opening the peritoneum, but the source of it could not be found, and the abdomen was closed. Thus this case is

more or less a repetition of the previous one both as regards the history and the condition found at the operation. There is no further note about the vomiting, so presumably it was not a marked feature, nor is any reference made to the action of the bowels.

Autopsy.—There was hæmorrhage into the substance of the pancreas and fat necrosis in the mesentery and on the peritoneal covering of the viscera.

I will now draw your attention to two cases in which the symptoms were different from those which I have just narrated to you.

(3.) J. H., a male, æt. 51, was admitted under Dr. Shaw on September 10th, 1901, for stercoraceous vomiting. He gave a history which suggested an attack of peritonitis three years previously. On September 8th he had breakfast at 8 o'clock, and before 11 a.m. the bowels were opened twice. At 1 o'clock he began to be sick, but had no severe pain, although he had some pain later in the afternoon. The following day the pain recurred and the vomiting became frequent. He took some purgatives, but without effect. On the day of admission the vomit was said to be stercoraceous.

On admission.—The abdomen was considerably distended and its movement impaired, but it was neither rigid nor tender, except on deep palpation. Pulse very feeble—130 per minute. Acute intestinal obstruction was diagnosed.

Autopsy.—Fat necrosis was found around the pancreas, with some matting of the omentum, and many hæmorrhages into the pancreas itself. There was slight jaundice of the conjunctivæ.

This is, as regards symptoms, a different class of case altogether. Here we have severe abdominal pain associated with absolute constipation and vomiting, the vomit ultimately becoming stercoraceous, in which there was distension of the abdomen, and but little or no evidence of inflammation of the peritoneum. The symptoms suggested an intestinal obstruction.

(4.) The next case was a man, æt. 42, who was admitted under Dr. Perry, on September 18th, 1898, and who gave a history of acute abdominal pain with absolute constipation for two days. This patient had had attacks of what he described as "colic" once or twice a year for several years, but the pain was not nearly so severe as that with which he suffered on admission. The illness started with an intermittent colic, sufficiently severe at times to "double him up." On the first day the bowels were opened four times, but after that there was absolute constipation. On the day following the onset of the attack he was much collapsed; he had only vomited twice since the onset.

Condition on admission.—Pulse, 100; temperature, 96°; a somewhat stout man who complained of very severe pain across the epigastrium, although he could not locate it definitely. He was very restless; the abdomen was not distended and it moved fairly well; it was not rigid, and firm pressure could be borne. The case was thought to be one of acute intestinal obstruction.

Autopsy.—There was hæmorrhage around and into the pancreas, and extensive fat necrosis.

Again, in two very characteristic cases recorded by Dr. Bryant in the *Lancet* for November, 1900—one, a patient admitted under Mr. Dunn, and the other under himself—the same condition as in the cases already referred to was found, whilst in one case there was fat necrosis in the pericardial and mediastinal tissues also. In both of these cases the diagnosis of perforated gastric ulcer was considered the most probable, although acute pancreatitis was considered. In the first several stones were found in the gall bladder at the autopsy, and in the second a small calculus in the common duct, at the junction with the cystic duct.

There are, then, two main features to be noticed as to the signs and symptoms in the examples I have brought before you to-day, viz.,

(i.) Those simulating perforation of a hollow viscus, such as the stomach.

(ii.) Those simulating an acute intestinal obstruction.

From reading the text-book description, you might imagine that it was quite easy to differentiate between acute hæmorrhagic pancreatitis and a perforated ulcer of the stomach or duodenum. You are told that the latter is put out of court by the absence of a history of pain after food or of hæmorrhage from the stomach, or melæna; still, however satisfactory that may be for examination purposes, I am afraid you will not always find it of the same value in practice. Possibly some of you have seen a case of perforated gastric ulcer, in which there was no history of indigestion or pain after food, and you have to remember that an ulcer of the stomach may exist, or may even perforate, without giving rise to any previous symptoms. Some of you may have seen a young girl of 17 years of age who was admitted under me when I was taking charge of the wards for Dr. Pitt just before Christmas. She stated that she had

been quite healthy previous to her present illness and had never suffered from indigestion in any form. Twelve days before admission she had been seized with acute abdominal pain and was sick. This patient when admitted to hospital had a sub-diaphragmatic abscess from a gastric ulcer which had perforated.

I do not propose to-day to enter into the differential diagnosis of acute abdominal lesions, as they have been dealt with in clinical lectures published in the Guy's Hospital Gazette in 1889 and 1901. The point I wish to impress upon you is that if you meet with a case of acute localised peritonitis which you think is due to a perforation, but in which the typical history of gastric ulcer is absent, and the signs themselves are not distinctive, you may be dealing with a case of acute pancreatitis. I think it ought to have occurred to our minds in this case.

Now to take the other class of case where the symptoms simulated those of intestinal obstruction and of which there are a number on record. In Case No. 3 you will remember that after the first day the pain and vomiting persisted, and there was absolute constipation with abdominal distension. In Case No. 4 there was a very similar history. In Case 3 the bowels were opened twice on the first day, in Case 4 four times, and then followed absolute constipation. These cases are exactly like those of acute intestinal obstruction, resulting from a band, or from some other form of internal strangulation, with the exception that constipation is usually complete from the beginning.

Indeed these cases instance very clearly the difficulty of diagnosing acute pancreatitis with our present knowledge of the disease, and I do not know of a case that has been admitted into the hospital where the diagnosis of that condition has been made before operation, although it has been discussed and suggested as a possibility.

If you refer to the descriptions usually given of acute hæmorrhagic pancreatitis, you will find that it is said to occur in middle-aged stout males, and especially in those addicted to alcohol. The ages of the patients I have mentioned were 36, 33, 55, 51 and 42, and the ages in Dr. Bryant's two cases were 36 and 22 The onset is usually sudden, the pain severe, continuous or paroxysmal; the site of the pain is in the epigastrium; collapse may be or may not be a marked feature. The temperature is usually raised—100°–104° F.—and the signs point to a lesion in the upper part of the abdomen. In most of the cases no previous history of any preceding attack is obtained, and in most of them also, unfortunately, a rapidly fatal result ensues. Anæmia is another symptom which has been noted. The urine may contain albumen and casts, and sugar has also been found.

The cases I have told you of to-day presented many of these symptoms, but the patient who forms the subject of this lecture was not particularly stout. She passed some urine for examination, but unfortunately it was thrown away without being examined. But although glycosuria has been recorded in some cases, it is only in the later stages of the disease, and is therefore not of much value in forming a diagnosis.

With regard to the pathology of the disease, I will first of all relate to you the appearances found *post-mortem* in our case, as they are very typical ones. There were some old pleural adhesions, with scarring at the right apex; but no recent pleurisy. There was recent lymph over the liver, that being the cause of the pleuritic rub which was heard on the day of admission. The peritoneum contained a small quantity of dark-coloured turbid blood-stained fluid, and there was a little recent exudation of lymph in the lower part of the abdomen. The peritonitis was most marked in the upper part corresponding to the region of the lesser sac, the lymph here being much thicker and greater in amount than elsewhere. Numerous areas of fat necrosis were to be seen in the sub-peritoneal fat, the areas varying in size from a pin's head to a pea; the colour of the patches varied from a dead white to a pale yellow, all being paler than the surrounding fat. You can see these areas very clearly in the specimen which I have here. The colour of the necrotic areas varies considerably, sometimes it is a dead white, sometimes a milky white, sometimes an ivory yellow. The areas were more numerous in the sub-peritoneal fat of the lesser sac and over the pancreas than elsewhere. The pancreas was large, and the head was so also, confirming the observation with regard to it made at the operation. There was a large dark hæmorrhage into the head which you can also see, as also three small hæmorrhages on the posterior surface and another one on the anterior aspect. The mucous membrane of the stomach and duodenum was normal in appearance, as was also the gall-bladder, the latter containing some bile; the bile ducts were patent, and no gall-stones were present.

As far as the actual cause of the condition is concerned, I am afraid I have not very much more definite to tell you than in regard to the diagnosis.

There are, however, several anatomical peculiarities about the pancreas and its duct which you would do well to remember and which are drawn attention to by Deaver in an article in the *Journal of American Sciences*, for February, 1903, on "Diseases of the Pancreas," this paper giving a good résumé of much of the work on the subject. The usual condition is that the common bile duct and the pancreatic duct join and open into the diverticulum of Vater which communicates through a narrow orifice with the duodenum. Sometimes a second pancreatic duct exists, which leaves the main duct before it joins the common bile duct, and passing behind the latter opens into the duodenum above the diverticulum of Vater. The two ducts, the common bile duct and the pancreatic duct do not always unite before opening into the duodenum.

Now, as the pancreatic duct opens into the duodenum, and as that part of the intestine always contains bacteria, you can readily understand how easily organisms may gain access to the pancreas, especially if there be a catarrhal condition of the duodenum present, just in the same way as they reach the ducts of the liver, and set up a secondary inflammatory process there.

There are two views as to the causation of acute pancreatic disease—(i.) that it is due to a bacterial infection from the duodenum, or through the blood-vessels, or lymphatics, and (ii.) that it is due to the entrance of bile into the pancreatic duct. In this connection there are some interesting observations and experiments by two American observers, Halstead and Opie. They refer to a case of a fat man who died of the disease, and in whom there was found in the diverticulum of Vater, a calculus which was too small to block the opening of the pancreatic duct into the diverticulum, but too large to pass out of it into the duodenum; the pancreatic duct was bile-stained. In some experiments performed by them by injecting dog's bile into the pancreatic duct, a hæmorrhagic pancreatitis was produced.

These observers suggested that the acute pancreatitis might be due to retrojection of bile into the pancreatic duct, and they mention the case above related as an important one, inasmuch as the calculus formed a sort of pea valve, by means of which the communication between the common bile and the pancreatic ducts remained patent, and so allowed bile to get into the pancreatic duct, while the opening into the duodenum was blocked.

In a number of cases of chronic pancreatitis, and in some of the acute ones, gallstones have been found. They were present in one of the cases I read to you, and in both of Dr. Bryant's cases. Thus here we have a cause which may readily lead to inflammation of the duct, and as the common bile duct and the pancreatic duct, communicate with one another, it is readily conceivable how an inflammation in the one may spread into the other. If the introduction of bile into the pancreatic duct is an important aetiological factor, then we have two ways in which the gallstones may play a part, viz., one by setting up irritation with a resulting secondary infective inflammation, and the other mechanically by blocking up the opening into the duodenum, and so allowing the passage of the bile from the common duct into the pancreatic duct. In many of the cases there is no note of the presence of gallstones, and it is probable that in some cases infection may arise through the blood, or it may be dependent upon a catarrh of the duodenum, however that be set up. Another possible factor is injury. There is a history of falling downstairs in the case I have told you of to-day, and in many others traumatism, or injury in connection with operations in that region, have apparently had a close bearing on the case.

After all, however, our knowledge of the ætiology and pathology of this disease is very small; the points I have brought before you are only suggestive and include some to which I wish to draw your attention should it fall to your lot to have to investigate examples of this disease.

The bacillus coli communis has been found in the affected parts in a number of cases. It is the organism which is most commonly found in cases of acute peritonitis arising from infection from the bowel. It exists normally in the human body; and, as far as experiments upon animals go, it is harmless when taken from a healthy intestine, but in many diseased conditions it at once becomes virulent, and on being introduced into the peritoneum an acute inflammation develops.

In peritonitis secondary to acute inflammation of the bile ducts this bacillus is often the only one found, and it is possible that it may play the same part in some of the cases of acute pancreatitis.

The next point of interest is the fat necrosis which is so constant a feature of these cases,

but of which the pathology is obscure. It is said to be produced by the action of steapsin, splitting up the fat into free acid and glycerine; the fatty acid combines with a lime salt, and the result is the formation of the whitish patches previously described. This necrosis is probably the result of interference with the discharge of the pancreatic fluid, and the consequent escape of it into the tissues, the areas being usually most numerous in the region of the pancreas. The only difficulty in the way of this explanation is the presence, in some cases, of fat necrosis in the pericardial and mediastinal tissues of which the solution must be that the fat-splitting ferment gains access to either the lymph or blood streams and so reaches the more distant parts.

Experimentally fat necrosis has been produced by ligaturing the pancreatic duct and then stimulating the gland with pilocarpine; and associated with this hæmorrhage has taken place into the gland.

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Wednesday, March 2nd and 9th, 1.30 p.m., Clinical Surgery, by Mr. Symonds.

Saturday, March 5th and 12th, 1 p.m., Clinical Medicine, by Sir Cooper Perry.

Monday, February 29th, Lecture by Mr. Higgens.

Monday, March 7th, Lecture by Mr. Fagge.

Guy's Hospital Dental Society.

A meeting of the Dental Society was held on Friday, February 19th, at 5 o'clock in the Lecture Theatre. Mr. W. A. Maggs, president, occupied the chair, thirty-nine members being present.

A paper was read by Mr. J. S. Mawer, on Anæsthetics used in Dental Practice, in which he discussed those in common use, both local and general.

The paper was listened to with great interest, and was followed by a short discussion led by the President.

Casual communications were brought forward by Messrs. Prideaux, Poyton, Williams, Pilbeam, Husbands, Nibbs, and Randall. That brought forward by Mr. Husbands consisting of a portion of a mandible of a man aged 62 containing an unerupted canine tooth lying horizontally below the roots of central and lateral incisors. It had given rise to no symptoms and was discovered by accident on post-mortem examination.

Notes from Skin Outers.

Scabies.

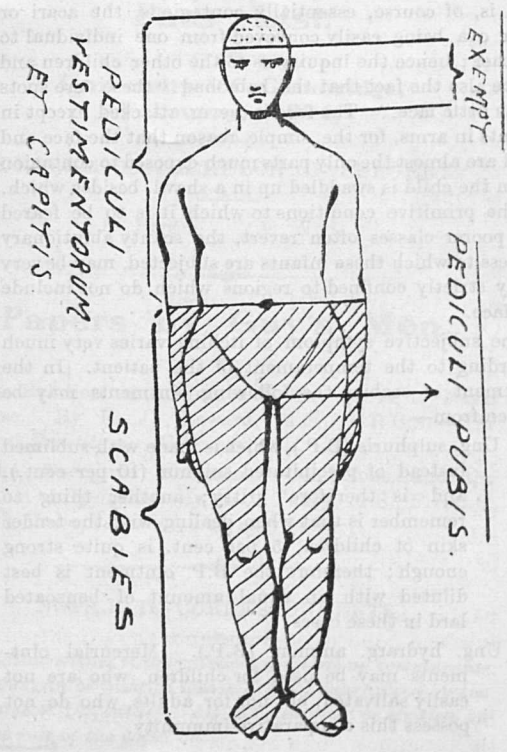
"Have any of the other children got it, ma'am?"

"Yus, doctor, they 'ave, and the baby's got these 'ere spots on 'is little face."

The patient was a small girl aged about 10, brought in by her mother, who was carrying a baby in her arms, and confessed to several other children of intermediate ages. The girl was affected by a pustular rash affecting interdigital spaces, wrists and lower forearms.

On careful investigation the characteristic "runs," *i.e.*, the dirt-blackened "burrows" of the female acarus beneath the horny layer of the epidermis, were demonstrated here and there in the eruption. And as these "burrows" or "cuniculi" form the primary lesion they merit a few further remarks.

They are seen as short black lines on white elevations, usually found between the fingers, and are caused as above said by the impregnated female acarus scabiei, or sarcoptes hominis, tunnelling her way underneath the superficial layers of the skin, her track being rendered black by excreta, ova and extraneous dirt; a small vesicle marks the end of the run. Here it is as well to warn the tyro that the female acarus is by no means so readily caught as might be imagined. When caught she



is just visible to the naked eye; the ova in the run are easier to get.

Sir Cooper Perry pointed out that in many cases these characteristic runs were not to be found, the intolerable itching causing the patient to destroy them and the vesicles by scratching, and frequently, as in the present case, the rash becomes a pustular one by the secondary inoculation of pyococci. He also observed that this pustular stage was most often seen in children and debilitated subjects, and several of the models in the museum were formerly labelled scabies purulenta vel cachectica. If, then, no runs are to be found the diagnosis must rest chiefly on the distribution, and in some cases the result of treatment.

The following is a good rule to remember. If the patient be standing at attention and a horizontal line be drawn across the body at the level of the umbilicus, all the parts below this may be looked upon as the happy hunting ground of the acarus scabiei, while above the line up to the neck, scratch marks in elderly patients are more likely to be due to the pediculi vestimentorum, and just to complete this geography may be mentioned the pediculi capitis and pubis, whose habitat is clearly indicated by their names.

The scabies rash, then, consisting of runs, vesicles and pustules, as the case may be, with consequent scratch marks, is in the front of the body, mainly confined to below the umbilicus, while posteriorly signs of the disease are most often found on the buttocks.

It is, of course, essentially contagious, the acari or their ova being easily conveyed from one individual to another; hence the inquiry as to the other children and hence also the fact that the baby had "these 'ere spots on 'is little face." The face is never attacked except in infants in arms, for the simple reason that the face and head are almost the only parts much exposed to contagion when the child is swaddled up in a shawl, besides which, in the primitive conditions to which it is to be feared our poorer classes often revert, the scanty ablutionary process to which these infants are subjected, may be very likely strictly confined to regions which do not include the face.

The subjective symptom of itching varies very much according to the temperament of the patient. In the treatment of scabies the following ointments may be chosen from—

1. Ung. sulphuris (B.P.), which is made with sublimed instead of precipitated sulphur (10 per cent.), and is therefore gritty; another thing to remember is that when dealing with the tender skin of children, 5 per cent. is quite strong enough; therefore the B.P. ointment is best diluted with an equal amount of benzoated lard in these cases.
2. Ung. hydrarg. ammon. (B.P.). Mercurial ointments may be used for children, who are not easily salivated, but not for adults, who do not possess this comparative immunity.
3. Ung. styracis (Guy's Pharmacopœia).
4. *Ung. balsam. Peruviani (Guy's Pharmacopœia).*
5. The following ointment—

β. naphthol (in fine powder)	...	...	grs. 30
Ac. salicylic	...	...	grs. 30
Ung. paraffini ad	...	...	ʒj.

M. ft. ung.

Whichever of the above remedies be used, it is best applied at night, after a thorough warm bath with soft soap, which not only removes much extraneous dirt, but by softening and relaxing the tissues of the skin generally, renders the female acarus more amenable to argument.

The process must be thorough, but should not be pushed to the extremity of causing inflammation, or aggravating it if already present.

Lastly, in private practice, it is useful to remember that scabies may occur even in cleanly people, and this very cleanliness may so far modify the appearance of the rash, that difficulty of diagnosis may be caused, and also, although highly contagious, it may remain for a long time confined to one child or person in a house.

Physical Society.

A Pathological Meeting of the Society was held in the Wills Library on Saturday, February 13th, at 8 o'clock, under the chairmanship of Mr. K. Black. The following specimens were shown:—

Horse shoe kidney from a child eighteen months old.
Mr. H. F. B. Walker, M.B.

Ruptured right ventricle of the heart.
Mr. O. V. Payne, B.A.

Fœtal ascites. Mr. Stevenson.

Multiple abscesses of the liver secondary to appendicitis. Mr. Miller, B.A.

Microscopical preparation of Madura foot mycosis—Streptothrix Maduræ. Mr. Mollison, B.A.

An encephalic fœtus. Mr. Reinhold.

An amputated finger showing excessive fungating granulations from a penetrating wound into a phalangeal joint due to a bite. Mr. Maybury.

Normal kidney injected, the arteries with picro-carmine and the veins with Prussian blue.
The Chairman.

A lengthy discussion took place upon the above specimens, in which Messrs. Maybury, Mollison, O. V. Payne, Robinson, Reinhold, Stevenson, Wallace, F. L. Thomas, Goss, Bowen, the Chairman and Mr. H. T. Hicks took part. The meeting was adjourned about a quarter past ten.

The next meeting of the Society is on Saturday, February 27th, in the Smoking Room, Mr. E. H. B. Milsom in the chair. Mr. N. I. Spriggs will read a paper on "The Diagnosis and Treatment of Coma."

Acute Nephritis after Measles.

M.A. C.E., æt. 10 months, was admitted into Isolation ward on January 26th, with a rash and a cough. The family history was unimportant. The child had been fed from the breast, and had enjoyed good health, until a fortnight before admission. Then she began "to get poorly." She had had a cough for the last week, and had been feverish for a few days before admission. The day before she had a discharge from the eyes, and they could hardly be opened. On the actual day there was a nasal discharge. She was sick once before admission. The rash appeared on the morning of admission.

On admission on January 26th.—Temperature 104·4°, pulse 160, respiration 44. There was a blotchy macular rash over the chest, head, arms, and legs, and there was no doubt whatever that the patient had measles. In the chest numerous rhonchi and râles of a consonating character were heard.

Patient was put on belladonna and a diaphoretic mixture. In two days' time, January 28th, her temperature was normal, and kept so until February 2nd. The rash gradually disappeared, she still had an irritating cough.

On February 2nd she began to take her food very badly and diarrhœa also set in. From this time until her death on February 15th, she had persistent vomiting and diarrhœa. Albumen water, in small and frequent feeds, was the only food she could retain.

The diarrhœa could not be checked. She was obviously very short of fluid and so was infused frequently into the axillæ. She also had strychnine in large doses. However she gradually became weaker and died on February 15th.

At the autopsy scattered areas of broncho-pneumonia with some collapse were found in both lungs. The kidneys were found to be much enlarged—the result of acute nephritis. The pyramids were deeply congested and the cortex pale and swollen with fine petechiæ. The stellate veins were enlarged. The two kidneys together weighed ninety grams—I believe the normal weight of both kidneys in a child ten months old is between twenty and thirty grams. At the autopsy the urine was drawn off and was found to contain much albumen. There were no clinical signs of nephritis, and consequently no attempt had been made to secure any urine for testing.

Looking through the Medical Reports since 1888 to 1902 I find there had been one hundred and seventy-three cases of measles in the hospital, ninety-eight being admitted since Isolation was opened in 1901. Of all these only one, in 1889, was indexed as having albuminuria. This was written up as, "Acute Laryingitis after measles. Tracheotomy. Broncho-pneumonia and Albuminuria," and the possibility of it being a case of diphtheria must not be overlooked. During the same period I found that there were fifty-three autopsies on measles and in none of these was any nephritis found. Of course, as most of these cases were very young children, it is conceivable that the urine was seldom tested.

The case I have reported was undoubtedly one of measles. The history, the discharge from the nose and eyes, and the rash, were quite conclusive to all who saw the case. In addition, a brother and sister of this patient are at the present moment suffering from measles, one being warded in Isolation.

Special Notice.

Guy's Hospital Reports.

VOLUME LVIII. of the Guy's Hospital Reports is now published. The next issue of the GAZETTE will contain a review of the contents of this volume. One of the articles is a lengthy one on Malignant Disease of the Stomach, with an appendix of cases occurring between 1826 and 1900. This will probably prove a most useful addition to the Hospital's medical literature.

Pass List.

University of Cambridge, February, 1904.

DEGREE OF BACHELOR OF SURGERY.

E. Bigge. A. Wylie.

Papers by Guy's Men.

The Relation of Asthma and Hay Fever to Nasal Disease. By F. J. Steward, M.S., F.R.C.S.—*The General Practitioner*, February 20th.

Some Deceptive Abdominal Conditions and the Question of Operation. By A. H. Tubby, M.S., F.R.C.S. *British Medical Journal*, February 13th.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Artificial Feeding of a Premature Infant in the Incubator.

At birth, on November 26th, 1903, the child, a boy, weighed three pounds eight ounces, his length was fifteen and a half inches, and he was of about thirty-five weeks' gestation, according to the mother (dating from the end of the last menstruation on March 28th, 1903).

Feeding was commenced eight hours after birth; two drachms of warm water with about half a drachm of milk-sugar were given every four hours.

On the third day, two drachms of milk from the mother's breasts were given two-hourly.

From the third to the sixth day, the breast-milk feeds were increased to half an ounce every two hours.

On the seventh day, one ounce of breast-milk was given two-hourly, day and night. This was continued until the twelfth day when Paget's Food (No. 1.)* was substituted for the mother's milk, one ounce being given two-hourly.

On the fourteenth day, one and a half ounce feeds of Paget's Food were given two hourly.

About the sixteenth day, two-ounce feeds (Paget's Food) were given two-hourly throughout the day and three-hourly at night. The last mentioned feeds were continued until the beginning of the sixth week, when the Paget's Food was given in the same quantity but less diluted.† At the end of the sixth week he was taken out of the incubator and put in a cot near the fire; from this time he was fed as a healthy full-term baby at the second week.

The child was taken out of the incubator every morning and given a warm bath in front of the fire, beginning on the third day. After the bath he was carefully dried, thickly covered with cotton-wool, and returned to the incubator.

About the eleventh day there was constipation which lasted about a week; one drachm of "sweet oil" was given every day, and on two occasions half a drachm of castor oil in addition. With this exception the bowels were regular throughout.

Measurements of the child's head:—

Circumference	11 inches.	
Biparietal	$2\frac{3}{4}$	"
Bitemporal	$2\frac{1}{2}$	"
Occipitomental	$4\frac{1}{4}$	"
Occipitofrontal	$3\frac{1}{2}$	"
Suboccipitobregmatic ...	$2\frac{3}{4}$	"

Weight of child:—

At birth = 3 lbs. 8 ozs.
On third day = 3 lbs. 5 ozs.
At end of sixth week = 4 lbs. 2 ozs.

The length at birth was $15\frac{1}{2}$ inches.

The incubator was at first kept at a temperature of 90° F., but was afterwards kept at 94° F. The child's cry was very feeble for the first few days but soon improved considerably.

The Paget's Food was given because the mother had to go home; the mother's milk appeared to be quite normal in quantity and quality.

Pregnancy was complicated by an abdominal tumour (? ovarian cystoma), premature labour set in spontaneously and premature rupture of the membranes took place, the os being about one inch in diameter on admission.

The presentation was R.O.P., the uterus lying oblique with the fundus inclined to the left side. The tumour was entirely above the brim of the pelvis occupying the right side of the abdomen reaching to the umbilicus. Placenta and membranes normal.

G. S. R.

* The Paget's Food was prepared as below:—
One bottle of Paget's Food (No. 1) to 50 ounces of sterilised warm water with one packet of Sodium Bicarbonate supplied with the food.

† One bottle of Paget's Food to one pint of water and one packet of Sodium Bicarbonate

Case of Henoch's Purpura.

Dr. Hale White's clinical lecture, which appeared in the Gazette of January 30th, has induced me to write a few notes on a typical case of the above disease, which is at present under my care.

M. S., girl, æt. 5 years. *Family history:* unimportant: no rheumatic history.

History of present Illness: Patient was suddenly taken ill on January 7th with diarrhœa and vomiting, and on the 10th was brought up to me with the history of having passed pure blood associated with violent attacks of abdominal pain all that day. On examination, she was a pale child, with a rapid pulse, but no elevation of temperature, the tongue was dry and coated with patches of white fur, she complained of abdominal pain but nothing could be felt in the abdomen.

On the 13th I saw the child again, the vomiting had stopped, but she was still passing watery motions of pure blood with a little mucus, and with them there was a good deal of abdominal pain, colic and rectal tenesmus. She was given Dover's powder in grs. iij. doses 4-hourly. After this the symptoms abated somewhat, but recurred again on the 14th, with vomiting and so much blood and mucus that I decided to examine the abdomen under an anæsthetic in order to put out the question of intussusception, though no tumour was felt, the abdomen was somewhat rigid.

On the 15th my partner and I thoroughly examined the child under an anæsthetic. No tumour was felt, nothing found per rectum: then for the first time a few petechial spots were noticed on the abdomen, and we considered the case to be one of dysentery or ulcerative

colitis of children with slight purpura, that Dr. Goodhart speaks of in his book, only there was absence of high temperature.

She was given a starch and opium enema and put on a mixture containing lead acetate, dilute acetic acid and nepenthe; the next day she had improved, there was absence of pain, no motion, and the temperature and pulse were normal.

January 18th. Temperature 98·4°; more purpuric spots appeared, and the patient passed a very dark motion which contained blood.

January 20th. A crop of very large purpuric spots appeared on the buttocks and right elbow, some as large as a sixpence; preceding the appearance of those on the elbow, she complained of slight pains in that joint (this was the only time joint-pains were complained of throughout the illness). Diagnosis: Henoch's purpura.

January 21st and 22nd. Another gastro-intestinal attack of pain and vomiting with passage of blood per anum, which passed off on the 23rd. The spots are fading and leave brown stains like a bruise.

January 27th and 28th. Another attack. Temperature 99·4° occurring for the first time since onset of trouble; dark loose tarry motions.

January 29th. Attack passed off, leaving patient very well. The tongue, which had been furred in patches, presents the appearance of a "strawberry tongue."

January 31st. Another attack of abdominal pain and melæna. Starch and opium enema given.

February. Patient progressing favourably again.

The urine was normal throughout, and no disease could be found in the other organs. Gums healthy.

It is interesting to note that the case coincides exactly with the description of those in the lecture, viz., periodic attacks of abdominal pain, vomiting, diarrhœa, melæna, purpura occurring in crops, and slight joint-pains. Also that Dr. Hale White says: "There is no evidence that treatment has any benefit on the disease; all you can say is that the child appears to grow out of it."

That this seems to be the case is proved by the fact that nothing in the way of hæmostatic drugs or dieting seemed to stop or control these attacks; for the patient had at one time or another the following treatment:—

1. A mixture of bismuth carbonate, hamamelis, chalk and opium.
2. Dover's powder.
3. Starch and opium enema.
4. Saline injection per rectum.
5. A mixture of lead acetate, nepenthe, and dilute acetic acid.
6. Calcium chloride in doses (grs. x.) every hour.
7. Pulv. suprarenal gland (Armour & Co.) gr. iij. four times a day.

Diet.—Milk and soda, milk and lime water, veal broths, beef tea, and vegetable broths (strained), orange and lemon juice, etc.

Having tried the above lines of treatment without avail, it was with great expectations of something new that I read through the lecture on the Sunday morning, only to be disappointed by the above-quoted sentence; nevertheless I was able to asure the parents of the child that she would eventually grow out of the disease.

E. I. CLAXTON.

The Residents' Annual Dance.

On Thursday, February 11th, the Residents gave their annual dance. For some reason or other it had been postponed from last December; and it was the opinion of all who had the good fortune to be present, that this was the best dance the Residents had yet given.

Few people, who have not tasted the sweets of the High Table, have any idea of the amount of work, worry, and responsibility which falls to a President in connection with such an undertaking as the above—and Mr. George Evans is to be congratulated on obtaining such an excellent result.

Mrs. Cosmo Bonsor had again very kindly consented to act as hostess, and Mrs. Taylor, Mrs. Lucas, Lady Perry, and the Matron were the Patronesses. Altogether about one hundred and forty were present, and from 8.30 p.m. until after 1 a.m., Burgess' well-known band enlivened the proceedings. Many of the Sisters were present and, we understand, enjoyed themselves.

Lady Perry, as on former occasions, had most kindly lent her drawing rooms and stairs to sit out on, and had also taken a great deal of trouble in decorating the rooms with marked success.

Owing to the most careful notes made concerning the 1902 dance, by the then President, Mr. Arthur Pearson (now in Central Africa), the whole organisation was much simplified, and a great deal of time and expense was saved to the Committee.

Appointments.

Civil.

Batchelor, F. Stanley, F.R.C.S., has been appointed Surgeon to the Dunedin Hospital, New Zealand.

Smith, M. Hamblin, M.R.C.S., L.R.C.P. Lond., Deputy Medical Officer, H.M. Prison, Manchester, has been transferred to H.M. Prison, Wandsworth, S.W.

Naval and Military.

Staff-Surgeon E. P. Mourilyan, R.N., is promoted to be Fleet-Surgeon in His Majesty's Fleet. Surgeon A. R. Thomas, R.N., has been appointed to the *Rambler*.

Captains E. M. Pilcher, D.S.O., and W. G. Beyts, A.M.C., are promoted to be Majors.

Letters to my Son.

IT was a great pleasure, my dear Freddy, to hear of your success at the recent "Second" examination. You will shortly, I presume, undertake that appointment, that first, *entertaining, exhilarating, tedious, worrying,* annoying, and wholly delightful appointment, which is the reward of the studious. You will join the numerous ranks of the Surgical Ward Clerks. It is a position, which, in anticipation, realisation and perturbation, will give you an entirely different sensation from any you have yet experienced.

We have it on the best authority that no man can serve two masters; you will have to serve, or pretend to serve, ten, more or less legitimate masters, and innumerable illegitimate ones. You have your own Surgeon, your House-Surgeon, one Clinical Assistant, six Dressers, and last, though not by any means least, there is the Surgical Registrar.

In the morning you will go round with the Registrar. This is a not wholly unenjoyable process, provided that you have previously fulfilled certain necessary conditions. If you have reported on all your new cases, and kept your old reports up to date, your progress will somewhat resemble a Triumphal Procession. Your reports will be read, and, possibly, favourably commented upon, and you will feel yourself a Personage. But neglect these necessary preliminaries, and your position will be woefully different. You will find yourself most uncomfortably "ragged," and you will feel, as you really are, very small beer indeed.

A surgical report, my dear son, is not a difficult thing to compile, and there are various ways and means of compilation. The simplest plan is to get the Clinical Assistant to do it for you. Understand, I do not commend this method; *au contraire*, there are two very good reasons against it. Primarily, this way, obviously, precludes any possible advantage to yourself: and, secondarily, the Clinical Assistant will most certainly decline to meet you half way by inclining to your views in this matter. The man who can persuade a Clinical Assistant to do Ward Clerks' work, has mistaken his vocation. He would give an added lustre to the "Corps Diplomatique," but as a mere Surgical Ward Clerk, his talents are wasted.

The average man usually manufactures his report, in the following manner. He approaches the patient as though he were Sir Astley Cooper, Lord Lister and, Sir Andrew Clarke, all rolled into one, with Dr. Horrocks thrown in as a make-weight. He feels the pulse, not because he derives any information from so doing, but because it is so obviously the correct thing to do. He then asks the patient's name, address and age, with a gravity of demeanour, and a power of rhetoric worthy of a better cause. It is customary to state, in the report, the reason why the patient has been admitted. A word of advice in this connection: As a surgical ward clerk, you are not allowed to make a diagnosis; it is considered an effort beyond your embryonic powers. Therefore, if a woman is admitted because her husband, lover-like, stroked her hair with a coke-hammer, you will say she is suffering from "injuries to her head." It is for the Surgeon with his vast experience, and for the Registrar with his fund of technical knowledge, to make the diagnosis, and say whether or no, there is a scalp-wound. The example I have given you, is, by reason of its frequent occurrence, rather a good one. You will frequently come across cases of swollen head during your stay at the Hospital, of interest either as pathological disease or functional derangement. Again, if in the "Boro'," one man hits another over the head with a file, the man who loses the odd trick will possibly be admitted to the Hospital. You may point out to him the beauty of our Hospital motto, which runs, if I remember rightly, "Dare quam accipere." You may not have much difficulty in making him understand its aptness.

In a case of this sort, it is not considered necessary to put down measles and whooping-cough among the previous diseases; neither is it worth while to record the fact that patient has hæmorrhoids in his family. These things will not materially assist the surgeon in his treatment of the case. At operations, your duties are multifarious, yet elementary. It is a great feature of this appointment that your bodily health is admirably cared for. Great solicitude is shown, by your various masters, that all your muscles shall be duly exercised. You will become an expert in the gentle art of carrying slop-pails, and your efficiency as a porter will be manifestly increased. During the operation you will have a most difficult function to perform; you will have to efface yourself, and, for one of our family, that is always most difficult, my dear son. During the "take in" week, your labours will become more arduous, and your efforts will have to be more strenuous. Some of your duties will recall to you the time when you were a Lower Form boy at school. You will learn how to make drinkable tea, and your ability in opening tins would procure for you a remunerative engagement at a ham and beef shop. In one respect only does your position differ from that of the Lower-School boy. If you make mistakes, you will not receive a "clump on the ear" for your pains. It is not to be expected that a gentleman of culture and refinement, such as the average dresser is, will behave like a raw, hobbledehoy of a sixth form boy. Besides, you may be a bigger man than he is! It is a good appointment, that of Surgical Ward Clerk, my boy, and I hope that you will derive much useful information from it.

In it, as in Life itself, there is one grand idea to be followed. Be good natured to everybody, and everybody will be good natured to you. Behave like an ill-mannered cub, and you will be treated as one. And that, my dear Freddy, is the confirmed opinion of

Your Affectionate Father,

CHESTERNUT.

Nurses' Choral Society and Students' Glee Club.

One of the most successful concerts of the above society which we have ever attended was given on February 16th under the direction of Mr. Henry Taylor. The performance was given as usual in the Court Room, which was well filled by an appreciative audience. It was decided that the choirs should confine their attentions to the rendering of various glees and part songs without producing any work of magnitude as has been done in former years. We must certainly congratulate the conductor on his achievement. The voices were exceedingly well balanced, the parts well sustained, and the songs and instrumental music with which the programme was complete, all tended to result in a most pleasing and attractive performance. Nurse Margaret Taylor was as usual at the piano and was indispensable.

The proceedings opened with Barnby's "Gather ye rosebuds" by the full choir, which was excellently rendered. "Integer vitæ," which followed, given by the men, took our thoughts back to public school days—many years ago now—and was most enthusiastically received. Mr. Barker, whom we have not had the pleasure of hearing before, obliged next with Handel's "Where'er you walk." Mr. Taylor then showed to what a very high state of perfection he had brought the choirs, with a most pleasing rendering of Smart's "Ave Maria." Messrs. Hammond-Smith, Goss and Felton next delighted the audience with two of Jarvis' trios, "Peter Piper" and "Jack and Jill." Mr. L. Ransford, whom we have quite come to look upon as a "Whistling Rufus" of our own, gave "Dan Cupid hath a garden" (German), and was deservedly encored. Another part song was given by the full choir, "It was a lover and his lass" (Booth), and then Sister Lazarus delighted us with "The parting hour" and "Spring again" (Ellen Wright). The men followed with the well-known "Thuringian Volkslied," which was a great success, and this was in turn succeeded by a song, "Sing me to sleep" (Greene). It is the first time that we have heard Nurse Humphries, and we sincerely hope that it is not the last. Another trio by Nurses Smith, Leather and Crocker, "Orpheus with his lute" (German), was much appreciated, and a grand rendering of Eaton Faning's "Daybreak" brought the first half of the programme to a close.

In the second part, the full choir gave Stevens' "Ye spotted snakes," and Nurse Woodward then took the house by storm with a violin solo, "Romantische Stücke" and "Obertass" (Wieniawski). Nurse Woodward's performances are well known at Guy's now. We can only say that we have never heard her to greater advantage. Mr. Goss, although labouring under a severe attack of influenza, scored a success with Stephen Adams' "Nirvana." The full choir next gave Leslie's "Lullaby of life," in which the bass voices were heard to great advantage. Sister Lydia then sang "Swallows" (Cowen), and in response to repeated calls, gave Behrend's "Daddy" with much feeling and marked success. After this Messrs. Hammond-Smith, Reeve, Alan-Forty and Felton gave "Jenks's Compound" (Macy) amid much laughter, and with many evidences of careful practice and training. Mr. Alan-Forty was next before us with a pianoforte solo, which was excellently rendered, "Prelude" (Rachmaninoff). The next item was Lee Williams' "Peace," and we must say that it was the weak performance of the evening. Amid such general excellence it almost amounted to failure. It was rendered by the men, assisted by the contraltos. Nurse Dawson next gave a cello solo. The men then gave Mendelssohn's "Students' parting song" in excellent style. The voices were well together and the result most pleasing. A quartette which followed, "Good evening" (Seymour-Smith), was splendid. Nurses Dickinson and Du Boulay with Mr. Greene and Mr. Felton, obtained in the opinion of many the success of the evening. The full choir concluded with "The Vikings" (Eaton Faning), which was given in excellent time and with much spirit.

"God Save the King" brought a most enjoyable evening to a close at half-past ten.

The position of the society this season is a most satisfactory one. There are some sixty men and nurses attending the practices, with not a few new voices of much merit. A good working balance has been carried forward to next year.

Notices.

Royal College of Surgeons of England.

COURSE OF LECTURES FOR 1904.

Lecture Hour 5 p.m. precisely.

Hunterian Lectures.

Professor L. B. Rawling.—Monday, February 29th; Wednesday, March 2nd; Friday, 4th. "Fractures of the Skull, including Mechanism, Pathology, Complications immediate and remote, and Treatment."

Professor A. W. Mayo Robson.—Monday, March 7th; Wednesday, 9th; Friday, 11th. "The Surgery of the Pancreas."

Arris and Gale Lectures.

Percy J. Cammidge, Esq., M.B.—Monday, March 14th. "The Physiology and Chemistry of the Pancreas."

J. Herbert Parsons, Esq., F.R.C.S.—Wednesday, March 16th; Friday, 18th. "The Neurology of Vision."

Erasmus Wilson Lectures.

E. M. Corner, Esq., F.R.C.S.—Monday, March 21st; Wednesday, 23rd; Friday, 25th. "Acute Infective Gangrenous Processes (Necroses) in the Alimentary Tract."

Dental Society's Dinner.

ON Saturday, February 13th, the Dental Society held their Annual Dinner at the Trocadero Restaurant. A goodly number of the men of past years, with a strong contingent of present men and a fair sprinkling of visitors, did justice to the excellent fare and provided an audience for both speaker and performer which oscillated between the extremity of somnolence and the height of enthusiasm. The number of those present amounted to about one hundred and fifty.

The chairman, Mr. MAGGS, the society's urbane and popular president, having disposed of the loyal toasts in a few felicitous words, turned his attention to Guy's Hospital and its two Schools, the prosperity of which he proposed in an interesting speech. Dealing first with the changes in the Hospital buildings at present being effected, he passed on to the mention of the honours conferred upon Sir Cooper Perry, Sir Alfred Fripp, and Sir Alan Reeve Manby. He spoke with regret of the resignations of Mr. Newland Pedley and Mr. Badcock, the one of the lectureship in dental surgery, the other of the post of dental surgeon. The loss of the latter would be deeply felt by both students and staff. The president next referred in sympathetic terms to the illness of Sir Samuel Wilks, expressing the hope that this distinguished Guy's man would make a speedy recovery. He regretted that Dr. Hale White and Mr. Charters Symonds had been prevented at the last moment from attending the dinner, and in the absence of the latter he called upon Dr. Eason to respond to the toast of "Guy's Hospital and Schools."

Dr. EASON, in replying, spoke of Mr. Newland Pedley's pioneer work for the Dental School, incidentally saying that if this gentleman had done nothing else, he would still have a just claim to fame in the fact that it was he who secured the services of Mr. Maggs for Guy's. He also spoke of the admirable work done by Mr. Rowlands in his coaching classes for the general subjects of the L.D.S. examination.

Mr. ROWLANDS proposed the health of the Dental Society, making special reference to the papers read by various men with the inevitable stimulation to original thought brought about thereby.

Mr. DOWSETT replied for the society. Referring to its inception he announced that one of those responsible for this was present that night in the person of Mr. Walter Wood, of Brighton.

Mr. WYNNE ROUW, whose speeches are always one of the features of the evening, provoked much laughter by his reminiscences of the "Old Troc" of his student days. He gave us to understand that he had played a large part in several of the entertainments. The terror of the company even in those days were the "visitors," a polite name for the avengers of the majesty of law, and he drew a striking parallel between these gentry and the unfortunate representatives of the Examining Board who were present as the guests of the chairman. He accordingly invited the company to appease the visitors, both malign and benign, by drinking their healths.

Mr. A. S. UNDERWOOD replied for the visitors in an amusing speech, in which he disclaimed all sinister motive. The subject that interested him most as an examiner was the question of double qualification for dental men. At present the opinion of the majority of his colleagues was, that so long as the present high standard of general information was demanded from candidates, so extensive an innovation as the enforcement of a double qualification was absolutely uncalled for.

The health of the Chairman was proposed by Mr. PERCIVAL CAMPKIN, and Mr. Maggs having replied, the official programme came to an end.

The musical programme left nothing to be desired. Mr. Felton's songs ("Ho, Jolly Jenkin," and "The Drinking Song," from "The Rose of Persia") were admirably rendered with this singer's customary good style.

Mr. White is an excellent violinist but would be heard to greater advantage in a proper concert room. He played Mascagni's "Intermezzo" and Simonetti's "Madrigale."

Mr. Reeve has one of the most pleasing tenor voices in the Hospital, and his "O Mistress mine" was highly appreciated. The same performer, owing to the regrettable absence of Mr. Philson, gave an excellent short sketch of a dude and a Frenchman respectively in the throes of a recitation.

Mr. L. U. Ransford's whistling is quite remarkable. His notes are absolutely true and the whole effect is admirable. He gave Sullivan's "Lost Chord," with "Songs of Araby" as an encore.

The quartette, consisting of Messrs. Hammond-Smith, Reeve, Felton and Forty was most amusing. They gave two humorous musical travesties in "Jenks' Vegetable Compound," and "The Teacher and the Tack."

Mr. Alan Forty's services at the piano must not pass unrecognised; he is probably the most accomplished musician in the Hospital, and his officiation both as an accompanist and as a singer in the glees was invaluable.

The Dental Society is to be congratulated once more on a highly successful gathering.

Papers by Guy's Men.

An Address on Puerperal Sepsis. By Peter Horrocks, M.D., F.R.C.P.—*British Medical Journal*, February 13th.

The Treatment of Tuberculous Disease of the Tarsus. By Lawrie McGavin, F.R.C.S. — *Clinical Journal*, February 24th.

Congenital narrowness of the Pyloric Orifice a Cause of Chronic Gastric Disease in the Adult. Illustrated by Seven Cases successfully treated by Operation. By A. E. Maylard, M.B., B.S. Lond. Illustrated.—*British Medical Journal*, 20th February.

"Judge Not."

SEVERAL weeks ago an article on "The Advertising Doctor" appeared in the *Outlook*, taking as its text the resolution passed by the Ethical Committee of the B.M.A., condemning the appearance of the names of medical men in newspapers. After discussing and in the main agreeing with this verdict, the writer goes on to say, "Publicity given to good work done is essentially an act of justice, and we hold that the surgeon who saves a valuable life by his skill is as deserving of public mention as the dog that by his courage saves the little child from drowning."

By all means give men, from the devil upwards, their due. But, while any fool has the right to give a brave dog a pat on the back, it requires an expert to pass judgment on medical skill. The patient, as the central figure of the drama, might by some be thought to be in the best position to decide the question, but despite the exhortation of the poet (or was it a saint?), urging man to know himself, man, at least the *layman*, knows little enough of himself in health and still less in disease.

Praise from the public on matters medical is "commonly false and nought . . . . . for the common people understand not many excellent virtues." Bacon has likened public opinion to "a river that beareth up things light and swollen, and drowns things weighty and solid." Again, the public appetite dearly loves to be whetted by a sensational titbit—is it not the proud boast of the *Daily Mail* that it has the largest circulation in the world?—and although there may be people who do not believe all they read, even though it be printed in a halfpenny paper, yet if the matter be left in the hands of the man in the street, the master of claptrap would often elbow his rival of more solid, sterling worth out of the running.

Perhaps the *Outlook* would suggest that in addition to the tame dramatic critic a medical expert should be attached to each daily paper. Goodness knows that they are in sore enough need of a medical pilot to steer them clear of the medical pitfalls into which they so glibly and unconsciously fall. Image with what horror, should this come to pass, the G.P., unfolding his paper over his morning rasher, would read the florid account of the medical Clement Scott of how he had dragged Mrs. Brown's windy baby from the jaws of death.

And now for the moral of these remarks. Good work, like good wine, needs no bush, and Nature, given time enough, will after all prove herself the best judge. A skilful man will find that the best advertisement he can have is the steady series of successes that sooner or later must be the outcome of all careful and intelligent work.

"THE ONLOOKER."

Reviews.

The price of books submitted for review should in every case be stated.

Handbook of Public Health. John Orr, M.D., F.R.C.P.E. (Edinburgh: E. & S. Livingstone.) 236 pp. 4s. net.

The author is of opinion that there is a demand for another text-book on this subject giving only the essentials for the student. We are inclined to doubt his statement, and further disagree with him when he says that the details of the popular text-books tend to bewilder the student.

The print is of good size and clear and the diagrams well done. Every department is too meagrely treated to make anyone take an intelligent interest in the subject. For example, the various methods of disposing of sewage are outlined and the economic side is entirely neglected. The short chapter on Vital Statistics can impart very little useful information to a man reading it for the first time.

Finally, the book purports to give as much information as is necessary to fit a man for a medical practitioner's life. We think the author fails, and can find little to recommend the work.

A Manual of Medicine. Edited by W. H. Allchin, M.D., F.R.C.P., Vol. V. Diseases of the Abdominal Organs. (London: Macmillan & Co.). 687 pp. 10s. net.

This, the final volume of Dr. Allchin's Manual of Medicine, is now before the public, and will be found to keep up the high standard created by the previous volumes.

Dr. Abrahams writes on diseases of mouth, pharynx, and œsophagus, in the course of which is a good article on the differential diagnosis of acute sore throat.

Dr. R. Hutchinson contributes a lucid and practical article on "Food and Diet."

On diseases of peritoneum Dr. Hale White is concise and admirably lucid.

Dr. Bryant, writing on "Diseases of the Abdominal Blood Vessels," makes free use of the Guy's Hospital post-mortem records for his etiology. We note our old friend the student, æt. 18, who died in this hospital with a hepatic aneurysm, has now found his way into a text-book on suppurative pylephlebitis. Dr. Bryant will be recognised as an authority.

The Editor reserves for himself the subject of diseases of stomach and intestines, which he treats fully and efficiently.

Those who have ordered the work will not be disappointed with this, the concluding volume.

Manual of Surgery. By Alexis Thomson, M.D., F.R.C.S. Ed., and Alexander Miles, M.D., F.R.C.S. Ed, Vol. I. General Surgery. (Young J. Pentland.) 763 pp.

This work, emanating from the Edinburgh School, is handy in size, the subject well arranged, and the text

clear. What engages one's attention most is the profuse and excellent illustrations accompanying each part. Preceding each chapter is a short description of the anatomy of the part under treatment.

Taking into account the numerous excellent text-books on the subject at present extant one would scarcely have thought there was any demand for the present work. It has nothing especially original in style or matter to make it likely to displace the present popular works.

The Direction of Hair in Animals and Man. By Walter Kidd, M.D., F.Z.S. (London: Adam and Charles Black). 154 pp.

This is an attempt to explain the direction of the hair in animals and man on mechanical principles and to demonstrate that in one part of natural science at least there is truth in the Lamarckian principle that acquired habits can be inherited. The author shows great powers of accurate and acute observation. Diagrams are numerous. The print is good and the style dignified. The book will appeal to that increasing class who "live to learn" and do not "learn to live." We think the author by his sound observation and reasoning is quite successful and convincing.

The Fate of the Ovum and Graafian Follicle in Præ-Menstrual Life. By Thos. G. Stevens. (Sherratt & Hughes, 59, Long Acre.)

This pamphlet attempts to demonstrate that maturation and subsequent absorption without rupture of the Graafian follicle occurs in the præ-menstrual ovary.

The ovum and Graafian follicle are traced to their recognised maturation and then the retrograde slips (removal by phagocytosis of the ovum by cells derived from the membrana granulosa, dissolution of cells of that membrane, and formation of granulation tissue, with its subsequent fibrosis, from the fibrous coat), are all clearly expounded.

The phagocytes (derived from membrana granulosa and NOT leucocytes), all enter through one opening in the zona pellucida, which, according to our author, is the most resistant structure.

Illustrations are well done, clear and plentiful; it only remains to see whether others derive a similar impression from their observation of sections of the young ovary now that Dr. Stevens has advanced his views.

Nursing News.

MATRON'S OFFICE.

Nurse Worthington left the hospital on completion of her three years' training on January 30th, 1904, and Probationer Riley was appointed to succeed her as Head Nurse.

On February 4th, 1904, Nurse Gilbert, Head Nurse in the Theatre, left the hospital on completion of her three years' training. Nurse Morley, Head Nurse in Naaman, has been transferred to the Theatre, and Probationer Woodward appointed Head Nurse in Naaman.

Nurse Crampton, Head Nurse in the Out-patient department, has been transferred to Stephen, and Probationers Farrar and Carr-Hill have been appointed Head Nurses in the Out-patient department.

Nurse G. Studdert left the hospital on February 10th, on completion of her three years' training, and Probationer Bingham has been appointed to succeed her as Head Nurse in Patience ward.

Nurse Foster left the hospital on completion of her three years' training on February 16th, 1904, and Probationer Eastmond has been appointed to succeed her as Head Nurse in Esther ward.

Probationer Lulham was appointed Head Nurse in Lazarus ward, on February 23rd, 1904.

We much regret to announce the death of Probationer Olive Barnard, who died in the Nurses' Sick Room on January 27th, 1904, after a short illness of pneumonia following influenza. The funeral service was held in the Hospital Chapel on January 30th, previous to the body being taken to Yatton for interment. Probationer Barnard entered the hospital for three years' training on October 1st, 1902.

Sport.

Football Fixtures.

SATURDAY, FEBRUARY 27TH.

G.H.R.F.C. I., v. Marlborough Nomads, home.
II., v. Old Merchant Taylors II., away.
III., v. Old Alleynians III., away.
G.H.A.F.C., I., v. Old Foresters, home.
II., v. Woodford Albion away.

SATURDAY, MARCH 5TH.

G.H.R.F.C., II., v. Wasps II., away.
G.H.A.F.C., I., v. Surbiton Hill, away.
II., v. Old Cranleighans, home.

WEDNESDAY, MARCH 9TH.

Guy's v. London (Final Cup Tie).

SATURDAY, MARCH 12TH.

G.H.R.F.C., III., v. Park House "B," away.
G.H.A.F.C., I., v. Normanhurst Druids, away.
II., v. Old Alleyn II., away.

SATURDAY, MARCH 19TH.

G.H.A.F.C., I., v. Old Harrovians, home.
II., v. Central Technical College, away.

Rugby Football.

Guy's v. University College Hospital.

This match was played at Richmond, January 18th; the day was fine and the ground dry, thus favouring the passing game which Guy's generally play. University attacked at the beginning, and Guy's had to defend their line for the first quarter of an hour. Our opponents working hard, prevented us from getting the ball in the scrum, and by good rushes carried the ball down to our line several times. At last we managed to get the ball, and from a good passing rush, Morgan scored under the posts, McEvedy converting. From now until the end, the match was simply a trial on Guy's part to see what score they could run up, the University defence having quite broken down. We ended up at half time, 29 points to the good; Earle, Saunders, Morgan and Harrison having scored. Soon after the second half opened, Morgan scored after a good run by McEvedy. Our forwards were now playing better and getting the ball out well. Jones picking up in front of goal, potted, and after Morgan had scored once more, Harrison also potted a goal. We ended up with nine goals, two potted goals and five tries (68 points) to nil. The tries were scored by Morgan, five; Harrison, three; Saunders and Earle, two, and Louisson and Jones, one each. Harrison and Jones dropped goals, and McEvedy converted eight tries.

REMARKS.—Husbands at full back was safe and always found touch. At three-quarters Harrison played very well, Jones also played a good game, but still has a tendency to stick to the ball a little too long. Morgan and McEvedy were in great form. Cutler was good at times, but does not get the ball away from the scrum quickly enough. The forwards after the first quarter of an hour played well, but even against weak teams they have great difficulty in getting the ball. Saunders was good in the open, but at times did not shove in the scrum.

Association Football.

INTER-HOSPITAL CUP TIE.—SECOND ROUND.

Guy's (holders) v. St. Thomas's.

Result.—Guy's 3; St. Thomas's 1.

This match was played on St. Thomas's ground at Chiswick, on Tuesday, February 16th, the ground being in good condition. St. Thomas's won the toss and played with the wind. For the first ten minutes our opponents held the upper hand, but at last the forwards broke away and Berry almost scored by a cross shot from the right wing. Guy's now played strenuously, and Plummer from the left wing put in a splendid low shot which hit the post and went behind. Just after this Edey, at back, in stopping a forward rush had the misfortune to strain the muscles of his right leg and had to retire. He returned shortly afterwards but being unable to use his leg went off the field altogether. The opposing forwards and halves were now playing a strong game, and from a right-wing pass their centre forward scored the first goal. From the re-start Guy's at once attacked more forcibly than ever, and shortly afterwards Litchfield scored with a difficult cross shot. Both teams put a good deal of "vim" into the play, but half-time was reached with the score 1—1.

On crossing over with the wind in their favour Guy's played up splendidly, the backs and halves being especially noticeable. At this point Plummer, who had taken Edey's place at back, brought off a great feat with a long and high kick from mid-field, which going straight into the mouth of the goal completely non-plussed the goal-keeper and scored. Our opponents made every effort to break through, but the halves and backs were too sound. Our next goal was the outcome of really good play on the part of Piper, who took the ball up on the left wing and finished with a splendid centre which Litchfield headed neatly into the net. Both teams played very hard to the finish, but Guy's were evidently the better and ultimately won by 3 goals to 1.

REMARKS.—The backs were good and sound, Plummer kicking and tackling well. The halves, perhaps, were the best part of the team, their energy and resource being most marked. Of the forwards, who all played well, Litchfield and Piper were the most prominent, the former scoring two good goals, and the latter working hard alone on the left wing. The team, as a whole, played a hard game and were never slack although playing a man short for most of the time. Team:—

E. A. Collins (Capt.) (goal); T. Edey, A. R. Wilson (backs); P. Pedrick, A. F. Denning, L. H. Frankenburg (halves); A. W. Berry, P. C. Litchfield, H. Baxter, E. N. Plummer, P. Piper (forwards).

Guy's v. London.

FIRST ROUND OF JUNIOR CUP.

This match was played on Wednesday, February 24th, at Hale End. Guy's won the toss, and played downhill. Our forwards soon got to work and penned London in their own half. Wearing was the first to shine and was charged off the ball just in time, a corner resulting. Berry took the kick, Wearing heading to Witts, who opened the scoring. On the re-start, we gained another corner, which Barker took, and enabled Jones to head through. We now seemed to be all over London, our forwards bombarding their goal, noticeably Berry and Jones. Finally, from a scramble in front of goal, Witts scored again.

HALF-TIME, 3—0.

After lemons, our forwards again got to work and had hard luck in not scoring. Some pretty passing now occurred, and Wearing further increased the score. London came away with a rush, and although they had open goal they shot wide. After this reverse, Berry ran the length of the field, and ended up with a fine centre, which Wearing turned to account. We now pressed London hard, and Berry centring again, enabled Wearing to perform the "Hat-Trick." RESULT, 6—0.

REMARKS.—Our forwards were excellent, Berry's centring being a feature of the game. The halves and backs were as safe as they could be, especially the Captain.

United Hospitals Hare and Hounds.

INTER-HOSPITAL CUP RACE.

By the kindness of the Blackheath Harriers this was run over a heavy ten miles course in the Blackheath district. Bart.'s and Guy's sent teams, London who had originally entered a team withdrawing their entry. The first-named hospital had a strong team out including W. B. Grandage, the Cambridge half-blue, but we were unfortunate in that Pilbeam (last year's individual winner) was quite untrained, though with great sportsmanship he decided to turn out and assist us.

Both teams ran with great determination, every man on each side getting the last ounce out of himself, Bart.'s eventually winning after a keen struggle by one point. Candler and Carr ran together for about 6½ miles, when the Bart.'s leader, forcing the pace, gradually drew away, ultimately getting home very comfortably by about five hundred yards, with Grandage a similar distance behind the second man.

The trail was most excellently laid by Tom Crafter, Esq. (B.H.), and the timing and starting duties were undertaken by O. S. Norton, Esq. (Capt. U.H.H. & H.), to both of whom our best thanks are due.

Placings and times :—

			M.	S.
1	A. L. Candler ...	Bart.'s	67	10
2	T. E. A. Carr ...	Guy's	69	14
3	W. B. Grandage ...	Bart.'s	71	15
4	H. Stott	Guy's	71	52
5	V. Townrow	Guy's	73	30
6	G. W. Lloyd... ...	Bart.'s	73	38
7	E. L. Pilbeam ...	Guy's	76	1
8	M. M. Adams ...	Guy's	77	22⅕
9	H. Gray	Bart.'s	79	28

Three aside counted :—Bart.'s 1, 3, 6=10
Guy's 2, 4, 5=11

This is St. Bart.'s fourth win, Guy's having won the Cup on ten occasions, St. Thomas's three times, and St. Mary's once.

Guy's v. Wellington College.

This was decided over six and a half miles of country at Wellington on February 13th. We had the first two men home, but the College just gained the victory by their excellent "packing." We were unfortunately without G. C. Birt.

ORDER AND TIMES.

		M.	S.
1.	T. E. A. Carr, Guy's	41	10
2.	A. L. Candler, St. Bart.'s...	41	20
3.	G. V. W. Lushington, Wellington ...	41	27
4.	W. K. Brown, Wellington	41	30
5.	C. M. Foster, Wellington	41	33
6.	C. A. Bradford, Wellington	42	1
7.	R. H. A. Morshead, Wellington	42	37
8.	V. Tounrow, Guy's...	43	5
9.	R. H. Muir, Wellington	44	10
10.	M. M. Adams, Guy's	46	40
11.	H. Stott, Guy's	46	43
12.	R. J. G. Turner, Guy's	—	

Wellington 3, 4, 5, 6=18.
Hospitals 1, 2, 8, 10=21.

Calendar.

February, 1904.

Sat. 27.—Physical Society's Meeting at 8 p.m. Paper on "The Diagnosis and Treatment of Coma," by N. I. Spriggs.
Messrs. Symonds and Steward's take-in; Drs., R. E. French and F. D. Crew; Cl., A. M. Webber.

Mon. 29.—April Appointment List opened.

March.

Thur. 3.—Messrs. Lucas and Lane's take-in; Drs., C. W. R. Preston and J. A. C. Greene; Cl., C. D. Pye-Smith.

Fri. 4.—April Appointment List closed.

Sat. 5.—Debating Society. Annual Ladies' Night. Subject for debate:—That the Modern Novel is decadent and has a pernicious influence upon Society.

Mon. 7.—Exam. for Arthur Durham Dissection Prizes.

Tues. 8.—Application to Medical School Office for Schedules for the 1st and 2nd Conjoint Exams. to be made not later than this date.

Thur. 10.—Messrs. Golding-Bird and Dunn's take-in; Drs., R. P. Lewis and A. Morris; Cl., P. P. Cole.

Sat. 12.—Smoking Concert.

Birth.

LAVERS.—On February 21st, at Mount Zeehan, Canterbury, to Dr. and Mrs. Norman Lavers, a son (Stanley Le Mesurier), grandson of the Rev. H. T. Lavers, of Melbourne, Australia, and of the late Rev. T. E. Hannum, B.A., LL.B., of London.

Marriages.

BATCHELOR—BUTTERWORTH.—On December 8th, 1903, Ferdinand Stanley Batchelor to Frances Marguerite Jenny Butterworth, both of Dunedin, New Zealand.

CAZENOVE—CRAWLEY.—On February 13th, at All Souls' Church, Leeds, William Reginald Cazenove, M.R.C.S., L.R.C.P. Lond., to Amy, younger daughter of Edward W. Crawley, of Leeds and Ilkley.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 414.] MARCH 12, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	101–103
Pneumonia. Clinical lecture by Dr. Hale White	104–109
Cæsarian Section	110
Notes from Skin Outers	110–111
Correspondence	112–113
Pass List	113
Appointments	113
In Lighter Vein	114–115
The Physiology of Pain	115–119
Sport	119–120
Reviews	120

Passim.

SIR SAMUEL WILKS is still in an anxious condition. Since the last note he has at times been in a very low state, refusing food, and very sleepless. Every now and then, however, he rouses from this condition of lethargy, and takes food freely. On Tuesday last he was sitting propped up in bed, and received, with pleasure, messages from old friends, and took fairly well of solid food. The wound, we are glad to hear, is shrinking as rapidly as the general condition will permit, and has from the first given rise to no anxiety, nor has there been any complication. Though his general condition gives cause for great anxiety, the fact that it varies from time to time, encourages hope that he may still recover.

THE Annual General Meeting of the Students' Club will be held on Thursday, March 24th, at 4.30 p.m., in No. 1 Surgical Class Room. Dr. Pye Smith will occupy the chair, and we would again appeal to men of all years to do their duty by attending this meeting. Last year one member complained that the Committee of the Students' Club veiled their business in impenetrable obscurity, suggesting that the fault lay at the door of the Committee. This, however, is not the case, the simple explanation being, that though Englishmen are proverbially proud of the principle of representation which holds good in all their forms of government, they are nevertheless content to stultify the same in action by their indifference as to the choice of representatives. The Committee are particularly anxious to have a good attendance of men, who are sufficiently interested in the business of the Club to take good care that suitable representatives shall be chosen to voice the opinions of the majority of the members and to discuss ways and means. That a keener spirit may be the result, it is requested that names of men willing to hold office on the Committee of the Students' Club shall be sent in to Mr. Ormond before March 24th, by those who are prepared to propose and second the election of those particular members.

THE Rugby Cup has at last been wrested from us, and if we mistake not the signs of the times, a few years are likely to elapse before it once more returns to our Smoking Room. The weather at Richmond on Wednesday last was all that could be desired and there was a very large muster of the supporters of both sides. The greatest enthusiasm prevailed amongst the

London men, who from all accounts had expected the victory which ultimately fell to their lot. There can be no doubt that we lost to a better all-round team than our own, in spite of the fact that our men did not show the form that they have done on previous occasions. While congratulating our opponents on a well earned success, the highest praise is also due to our own men for the thorough manner in which they prepared for the fray. There may possibly have been somewhat of an atmosphere of cock-sureness, permissible perhaps in a hitherto victorious team, but this did not result in careless play. Comments from the ladies on these occasions are always worth listening to, and one fair onlooker's remark, though not exactly sporting, at any rate puts the matter in a nutshell from the business point of view—"But why play again if they've won it," said she. "It's so silly to risk losing it."

The final round for the Association Cup will be played at Queen's Club on Thursday next. It is to be hoped that as many as possible will be there to cheer the eleven on to victory. This Cup should be made sure of, if possible, or we shall lose yet another landmark from the Smoking Room.

To-night's Smoking Concert bids fair to be a crowded one, for the tickets have been selling like wildfire, and it has even been found necessary to fix a limit to their sale. Since numbers are half the battle on these occasions, the concert should be as successful a one as any yet held. Those who were present at the last Smoker, will remember, that in the opinion of the many, the night was far too young when the concert came to an end, and one or two more "turns" would have been most welcome. This mistake will be rectified to-night, for it seems probable that the evening will be far-spent before the curtain is rung down for the last time on "A Curate is a Man," seeing that this production will occupy at least an hour, and will probably not commence until 9.30. As regards this latter, it is particularly hoped that men will keep as quiet as possible while the curtain is up. It is not an easy matter at any time for performers to make themselves heard at smoking concerts, and it is still harder when any attempt is made at dramatic performance. Those responsible for the concert feel sure that it is only necessary to mention this difficulty, for all to do their utmost to obviate the same.

The Debate on Saturday last was a most interesting and amusing function. "Ladies Nights" have always been popular, and the crowded smoking room on this occasion attested the fact that their popularity tends to grow rather than to diminish. There seems to have been some doubt in many men's minds as to whether the "8 o'clock," printed on the Society's placards, did not really mean "8.15," and this resulted in a less hearty welcome to the President than would have been accorded him if the majority of the men who filled the back benches had taken the trouble to be punctual. This unpunctuality has become the rule among the supporters of the Debating Society, and it is not at all an uncommon thing for the benches to be practically empty for the first fifteen minutes of the evening. However, the debate once fairly started, the interest did not flag for a moment, and events amply justified the selection of a subject of solid interest to both men and women alike, instead of falling back on the old trumped up questions of the rights, capabilities, and influence of women in the various spheres of life, which nowadays seriously interest nobody and bore not a few.

The meeting was made still more interesting by the enterprise of two lady speakers, one of whom was intrepid enough to lead the way in the general discussion, an event unparalleled in the annals of the Society. It was, however, a bitter disappointment to all the men present that no single member of the nursing staff could be prevailed upon to speak. If only a sister, for example, had expounded her views on the subject, it would have added much to the success of the evening; but it was not to be.

It is a taunt which is constantly levelled at the medical profession, that its members lack

those powers of imagination and of sentiment which spring eternal in the breast of the most average layman. The obvious reply to this accusation is that the medical imagination has been trained into a highly specialised faculty (witness the diagnoses that can be made by the physician in his prime), and that, so far as lack of sentiment is concerned in dealing with disease and pain, "an ounce of help is worth a ton of pity." But that the younger members of our profession are not entirely destitute of imagination in its crude and undifferentiated form, the crowd that collected in Queen some few days ago to witness a Cæsarian section, afforded a striking proof. Now the importance of seeing this operation cannot be too highly estimated, but other operations of vital importance, which are performed often enough in the theatres, do not draw large audiences to the tune of eighty or ninety, as did this particular feat of obstetric surgery. There is something in a Cæsarian that savours of juggling, and if on this occasion the attentive crowd had burst into applause and given three cheers for the operator, when first the squeal of the child was heard and its small pink body was seen in the embrace of an enterprising Charity, nobody would have been particularly shocked or surprised.

It is to be hoped that the Inter-Hospital Assault-at-Arms will become an annual function, after the highly successful display at the German Gymnasium. Indeed it is difficult to understand the temporary eclipse that boxing has suffered from for the past few years. There is no reason why this sport should not become exceedingly popular again, more especially as it is said that there are one or two good men at Guy's who are at present hiding their light under a bushel. The goodly sprinkling of the Staff at the Gymnasium was a good sign and augurs well for the future of such contests. On this occasion Guy's was not exactly lucky in more ways than one; in fact fortune, in one item at any rate, was unnecessarily harsh, but post-mortems are objectionable things and bygones must be bygones. The Gymnasium Committee are the happy possessors of a good big balance in hand in spite of their somewhat heavy expenses, and Mr. Minett is to be heartily thanked for his hard work during this last half of the season.

The new Dressers' Room has many advantages over the old one; it is larger, lighter, and infinitely cleaner, but it is a question whether the glory has not departed. There was a sense of security on the ground floor, which is absent in this new compartment. Here there is a feeling that the enemy is all around. How can one eat a going-off supper appropriately without all the tuberculous on Lazarus balcony hearing more than the top notes of the paean of praise, or without the Assistant Surgeon, only one little storey above, tossing on a couch of unrest, reviling the very day when it was said that a man-child had been born? True the staircase is not without its advantages, at any rate at present, in weeding out the false friend from the true, but the distance that the dresser in the Women's will have to travel on a slack afternoon if he wish for temporary respite from the Boro' matron is incalculable, and will probably have the effect of making him, much against his will, assist his brother in distress in the Men's. Perhaps the sobering effect of the new room with its environment was foreseen by the authorities, and one cannot but admire the tact which prompted the selection of these new quarters. Without a doubt, however, the natural depravity of the dresser, which has hitherto occasionally made itself manifest in noise, will find a fresh channel of outlet, and fulfil itself in many other ways.

There are many innovations at present occupying the attention of the Works Department, but the ingenuity displayed by this hard working body on the top landing of the Surgical block is beyond all praise. A short cut to Astley Cooper and Cornelius has been devised. The idea at present is that you walk rapidly out of Patience, and, falling through an unprotected hole in the floor at this point, make the rest of your journey to either of the Accident Wards on a stretcher with a fractured base or whatnot.

Pneumonia.

CLINICAL LECTURE by Dr. HALE WHITE, October 31st, 1903.

Gentlemen,—I almost feel that an apology is due to you for lecturing on so common a disease as Pneumonia, because you see so much of it in the wards, and probably you have heard a good deal about it. But, on the other hand, there is no disease which it is more important you should know as much as possible about, because it is very frequent, and is the commonest, or almost the commonest cause of death. It exists all over the globe, so wherever you go you will be called upon to treat it. I thought we ought to make the lecture this afternoon entirely practical, so I have jotted down some points which seemed to me likely to be of use to you at the bedside. I need hardly say that a lecture on such a large subject as pneumonia does not pretend to be exhaustive, and you will notice a good deal, such as the pathology, is left out. To-day we will take lobar pneumonia and next week broncho-pneumonia.

First I would point out that lobar pneumonia is a disease which occasionally recurs, and we recently had an instance of that in Clinical. The man is now dead from his second attack of pneumonia. It is therefore unlike many specific fevers in this respect. Another point is that patients often assert that the pneumonia was induced by exposure to cold, and there seems no doubt that sometimes exposure to cold is a contributory cause, but that it can be the sole cause is, of course, absurd when you remember that the disease is due to a definite micro-organism. Very often the patient is of opinion that his illness was due to exposure to cold because he has had a rigor and feels cold, and he attributes the pneumonia to that coldness. Is it contagious? Well, epidemics of pneumonia have been recorded, but in the ordinary sense of the word the disease is not contagious. We admit here about one hundred cases a year, and we should therefore quickly learn if the disease were contagious. But certainly it seems to hang about certain houses. I have in my mind at present a house in which three cases of pneumonia have occurred in October. Not long ago I knew of three cases, all fatal, occurring in a fortnight in the same house. Anyone who has seen much of the disease will tell you the same thing, that while there is no evidence that it commonly spreads directly from patient to patient, it is not infrequent to get it from some common source in a house and for three or four inmates to be simultaneously attacked with it.

With regard to the disease itself, the patient usually says that it comes on with a feeling of coldness, shivering, and pain in the side. The pain in the side is very severe, and is worse on breathing and coughing. A very important practical point to remember in connection with pain is that it is occasionally referred to the abdomen; and unless you bear that in mind you may have the disagreeable experience of opening the abdomen for pneumonia. Let me give you a case in point which Mr. Symonds has recorded. It occurred in Clinical, and I will read Mr. Symonds' account: "The patient was a man æt. 42, who, a couple of hours before admission, while walking in the street, was seized with violent abdominal pain and sickness. When we saw him in the ward he was in great agony, rolling about in bed, with pain in the pit of the stomach, perhaps a little to the right of the median line. He was retching and vomiting. The diagnosis made was perforating ulcer of the stomach. It so happened that the physician in charge of this case arranged that he was to be called in in case of an emergency, and I had arranged to let him know myself. I did not think that some five hours delay would add to his danger, and it would allow time for a more complete diagnosis. So we arranged to meet in the ward at 11.30 p.m. I was the first to arrive in the ward, and on going to the man's bedside found him breathing rapidly, with dilated nostrils, great pain in the side, and the aspect of a patient with pleuro-pneumonia. This diagnosis was confirmed by my colleague, who arrived half an hour later." This was thought to be a case of perforating gastric ulcer because the patient referred the pain to the abdomen. Here is another one, which again Mr. Symonds mentions, of a woman to whom he was called one evening. She was seriously ill, with great abdominal pain and tenderness in the region of the gall-bladder, was somewhat sick, and a little jaundiced. The suggested diagnosis was suppurating gall-bladder. After considering her case, and noting that the pulse could not be counted at the wrist because of its rapidity and irregularity, it was decided that operation was out of the question. The woman went through an attack of pneumonia on the right side, and afterwards walked out of the hospital quite well. I do not think you could want two more instructive cases; they were both pneumonia, yet one was thought to be perforating gastric ulcer, and the other a suppurating gall-bladder.

The temperature in pneumonia is the next clinical point to which I would direct your attention. As you know, the rise is very rapid, often by the time the temperature is taken, after the rigor, it is 104°. The shortest case of pneumonia I have known lasted thirty-six hours from onset to crisis; the case was undoubtedly one of pneumonia, as was proved by the physical signs. The temperature having risen, it keeps at about the same level, varying not more than a degree for usually seven, eight, or nine days. And then you know that the common course of events is for it to fall suddenly. The most rapid fall I know recorded was in one of Dr. Samuel West's cases, where the temperature was being taken hourly. It dropped 7° in an hour. That gives you some idea of how rapid the crisis may be. Sometimes before the crisis you see a rise of temperature. Either that indicates that the crisis is about to come on, or else that the patient is about to die, because not infrequently there is an *ante-mortem* rise of temperature, probably due to exhaustion of the thermotaxic mechanism. As we have repeatedly noticed in the ward during the last month, the crisis is often preceded by what is called a pseudo-crisis; there is a drop in the temperature, and in a few hours it bounds up again, then it comes down and the patient feels better. Sometimes after the crisis the temperature bounds up again. It comes down with such a fall that it seems by a sort of rebound to go up again for half a day or a day. So you see it is clearly difficult sometimes to know which fall is to be regarded as the crisis. In the case of a man now in Clinical the temperature fell to the normal, then remained down for a few hours, then went up again and finally dropped. It is open to you to say that *this* was a pre-critical drop or that *this* was a post-critical rise. The only way you can settle that question is, with which drop did the patient feel very much better. In this case the patient expressed himself as feeling very much better with the first drop, so we concluded that *this* was the crisis, and a subsequent rise of temperature was a post-critical rise. In about one-third of the cases the disease does not terminate by crisis but by a slow fall of temperature occupying about three days. I think I have observed that this termination by lysis is more common when there is a great deal of pleurisy, and especially if the disease has followed influenza Sometimes you find that the temperature persists and does not fall when you would expect it to. Usually that means that a complication is present, such, for instance, as pericarditis or empyæma, or even endocarditis. However, there are undoubtedly cases in which, apart from any complication, the temperature takes weeks to come down to the normal; I have known one where it occupied three weeks in doing so. But when the temperature takes so long to come to the normal it is an open question whether you have not overlooked some complication.

One of the striking peculiarities of the disease is the respirations. There is no disease except hysteria in which they are more rapid, and the rapidity is greater than the increase of pulse, or the height of temperature would lead you to expect. I am fortunate in having seen a greater rapidity of respiration than I can find mentioned in any book. The pulse and respirations were the same rate—108. The patient was a young man, somewhat over twenty, and he got quite well. If you watch cases you will find that this rapidity of respiration is not due to lividity. The patient is not usually livid and may not be livid at all, but still the respirations may be very rapid. It is one of the peculiar features of pneumonia that the poison of it leads to rapid breathing. Nor is the rate of respiration proportionate to the amount of lung involved; it falls when the crisis occurs, although of course the amount of lung involved remains the same. Again, the constitutional symptoms themselves bear very little proportion to the amount of lung involved. A parallel is, that the toxæmia in scarlet fever is independent of the extent of the rash. The cough is often troublesome. If there is much troublesome cough, especially with but little expectoration, it is very suggestive of the patient having pleurisy. No cough is often said to be a bad sign, and so it may be, because it may indicate a certain amount of weakness. Persistent cough after a crisis often indicates that an empyæma is forming. Never overlook that point. Then, you get so accustomed to seeing the usual rusty tenacious sputum, that you are a little disconcerted if you come across an exceptional case in which the sputum is almost pure blood. Pneumonia may bleed as phthisis may bleed, and I have known failure to remember this fact lead to the diagnosis of phthisis in a case of pneumonia. We will leave the pulse until we come to the prognosis, because it is so wrapped up with that. The dry, hot, pungent skin is very characteristic.

The physical signs are best studied in an individual case, but I have made a note of some

practical points. In the first place, a Skodaic note at the apex will often lead you to suspect pneumonia at the base, especially in children. The greatest difficulty with physical signs is when the pneumonia is deep seated and does not come to the surface until perhaps days after the initial rigor. We have recently had a child in John ward, in whom the physical signs did not appear until some time after the onset, and then they appeared over the bottom of the lower lobe on the right side. It seemed almost certain that the process had begun at the extreme base of the right lung, over the diaphragm, and that it took some days for it to spread to the edge of the lung and come up at the side. The diaphragm is not infrequently affected by pleurisy, and we had one remarkable case in John ward, No. 11 bed, some years ago. The pleurisy led to unilateral paralysis of the diaphragm.

It is surprising how, if you are careful, you can detect the disease quite early. For instance, in a child in John, No. 5 bed, we thought that he must have pneumonia on account of his temperature, and so forth, and on going round the ward one day we found just a very slight dulness and a little prolonged expiration, and these signs the next day had developed into those of a typical pneumonic patch. I think of the early signs, I have found bronchophony most useful. If you suspect the case to be pneumonia, a little increased bronchophony may tell you some 12 or 24 hours before the other signs are definite, where they are about to appear.

A difficulty which you will meet with is, that it is sometimes not easy, when there is a good deal of pericardial effusion, to separate off the dulness due to the effusion into the pericardium from that due to pneumonic lung in contact with the pericardium.

The most important symptoms of a case of pneumonia, namely, a rise of temperature, rigor, rapid pulse, sweats, delirium, are not due to the pulmonary consolidation, but to the infection by the pneumococcus, and they may occur when the pneumococcus does not infect the lung at all. There is a case in point which was under me some time ago. Dr. Washbourn recorded it when he was working at the subject. The patient was aged 36 years, and his illness was ushered in by a rigor. He had persistent high temperature, rapid breathing, cough, herpes, and delirium. The general aspect was so like that of a patient suffering from pneumonia, that both the medical registrar and I, pointed him out to the students as having the exact appearance of a patient suffering from pneumonia. I need not read all the case, but it will suffice to say that the physical signs were such as might have been due to pleural effusion and solid lung. At the post-mortem the lung was normal save for compression, both to the naked eye and under the microscope, pus was found in the chest, and this was proved to contain no micro-organisms but pneumococci. That illustrates my point. You see you may have a patient with the general symptoms of poisoning, so like those seen with pneumonia, that he is used by the physician-in-charge and the medical registrar as a case to teach the students the symptoms of pneumonia. He dies; nothing is found the matter with his lungs, but he is found to have had an extensive pneumococcal pleurisy, with a pure cultivation of pneumococci in the fluid.

The last point about the symptoms is to remember how slight they may be in people who are worn out by any exhausting disease. Pneumonia is a common termination of Bright's disease, tubercle, heart disease, and diabetes, and you are very likely to overlook its presence because the symptoms produced are so slight.

My next points concern the prognosis; and the first is the age. To illustrate its effect from cases, I turned up my own case-book, and found it happened that the last half-dozen cases of this disease I had seen were in people over sixty. Five of them died; yet there was not in any of the cases any particular reason, apart from the age, why the outlook should have been bad. Not one of them was an alcoholic subject. Hardly anything bears more upon the prognosis than the age of the patient. Over sixty it is most grave; over seventy, almost certainly fatal. On the other hand, it is wonderful what young people will do in the way of recovery. I also took the cases of half a dozen young patients with pneumonia from my case-book. There is the case of a girl æt. about 15. Three days before I saw her she had been seen by Dr. Savage for acute delirious mania complicating pneumonia. Dr. Savage, I was told, thought she would die, and I confess I thought so, and so did the doctor who was looking after her. That was six months ago, and she is now completely well. There is the case of a young man æt. 20. The temperature did not come down for over three weeks, and he had bad pericarditis as well. He is now perfectly well. There was the case of a girl, æt. 15, who developed empyema, and coughed it up. Her expectoration stank so that one could smell it before opening the bedroom door: I never smelt such fearful

expectoration. She had septic diarrhœa, but the empyæma was drained and she got well. The next case was that of a schoolboy, who was comatose, had a temperature of 105° and delirium, with optic neuritis, and probably some slight pneumococcal meningitis. He got well. The next was a young man, æt. 25, who got a double empyæma with his pneumonia. He got well. The young man I mentioned, whose respirations were 108, got well. So there were half a dozen old people none of whom, except for their age, presented any particular reason why they should go under; yet five of them died. On the other hand, there were six young people desperately ill, and all recovered.

The habits of a patient are as important as his age; the drunkard rarely recovers. A fatal case we had this month in Clinical reminds us of this.

The next point to which I would direct your notice is the pulse, and you must pay attention to its force, to its frequency, and observe whether it is regular. If it has a slight force, if it is intermittent, or if it is very rapid, the outlook is very grave. The man, now in 4 bed in John ward, has a rapid, feeble, irregular pulse. (He died the day after the lecture was given.) I went through my case-books from the point of view of the pulse, taking a few instances at random. Here is a man of 34, just at the age to get well; a good healthy looking subject; and my note says "Apparently doing well in all respects, except that he has a very rapid pulse"; I heard that he died two days after I saw him. Another was a boy æt. 15, and again the note, before I knew he was going to die, was, "There is nothing against him, except the bad pulse." He died two days later. The third was a schoolboy, æt. 16. The only note appearing as to the prognosis was, that his pulse was very bad; he died also. You will remember, that pneumonia rarely kills by the lungs. The poison of pneumonia kills through the heart, most essentially.

The next point in prognosis is the temperature. If you regard—as I think you should—the temperature as an attempt on the part of the body to protect itself, or what is called a protective mechanism, you are not surprised to learn that pneumonia does better with a high temperature than it does with a low one, provided the temperature is not so high as in itself to be dangerous to life. The best collection of cases I know of, bearing on this question, are those published in one of the volumes of the Reports of the Boston City Hospital. All the cases they had there were grouped together, and it came out c early that if the temperature was over 106° the patients did badly; those whose temperatures ranged from 105° to 106° did not do so badly, but those in whom the range was between 104° and 105°, did better than those in whom it was between 103° and 104°, and those again were better than those between 102° to 103°, and so on, until those in which it ranged between 100° and 101°, or lower, did worst of all. Last spring, I remember, that that was most disappointingly brought home to me. I saw a man æt. about 28, and there was apparently no reason why he should not get well of his pneumonia, except that his temperature had never been over 101°. It was that which made me hesitate as to the prognosis. We were justified in our hesitation, because he died. So you see the temperature may be of considerable help to you in your prognosis. The same is true of broncho-pneumonia, but we need not go into that to-day.

Leucocytosis may be of help in prognosis, for, speaking broadly, the greater the leucocytosis the better the outlook. I have mentioned a man in John ward who had a bad pulse, but a good point about the prognosis in him, although he is thin and wretched-looking, is that he has a good leucocytosis—50,000 leucocytes. (The bad pulse was of more prognostic value than the leucocytosis, for he died). The leucocytosis is an increase in the polymorphonuclear cells. Although considerable leucocytosis is a good omen, pneumonia is not benefited by inducing the artificial leucocytosis, as for example can be done by giving nuclein. It is important to notice that all people with a considerable clinical experience are agreed that it is a bad thing to give antipyretics in pneumonia; and it is interesting in that connection to remember that they check leucocytosis, and possibly their harmful effect is due to that. In very severe cases there are normoblasts and megaloblasts in the blood, and they are of bad prognosis.

Of the complications which make you think the prognosis bad, two are meningitis and endocarditis. With these the prognosis is undoubtedly very bad. But the interesting fact is that it is not necessarily bad if the patients get pericarditis or empyæma. An important practical point, too, is that if the patient thinks he will die, it often happens that he does. That is notorious in many organic diseases, and it has been brought home to me much lately. The patient was a man æt. just under 40, previously a perfectly healthy man, accustomed to plenty of outdoor exercise; and the only thing we did not like about him was that he was fearfully

depressed about his own condition. Otherwise he was an ordinary, although severe case of pneumonia; he died two days after I saw him. You will hardly be surprised to hear that the debilitated people of whom I spoke just now, die if they suffer from pneumonia—people with Bright's disease, with tubercle, with diabetes, with heart disease. I must repeat, because it is so important, that in estimating the prognosis you will remember that it does not depend so much upon the amount of lung involved as upon the evidence of toxæmia, as shewn by the temperature, the pulse, and so forth. Absence of sleep is of bad prognosis. Our forefathers used to think that if the diaphragm was implicated the patient died. Fifty or sixty years ago they took a most gloomy view of diapragmatic pleurisy. No doubt they exaggerated the danger of it; but I should have said that if the pneumonia is associated with diaphragmatic pleurisy the outlook is not by any means as good as it is if the diaphragm is not affected. I have pointed out to you that it may lead to direct paralysis of the diaphragm. This summer I saw a man with pneumonia. He was a temperate man; he spent his time shooting, and had plenty of outdoor exercise, and we saw no reason why he should not get over his pneumonia save that he had a great deal of diaphragmatic pleurisy, and, to our regret, he died; I think such cases are not by any means uncommon.

The last note I have set down as affecting prognosis is that if patients sweat a great deal during the fever the outlook is bad, as it indicates a very severe degree of toxæmia; the skin ought to be dry, hot and pungent. Another thing which will influence you is that the mortality varies so much at different times. I am constantly pointing out in the wards the curious fact that specific fevers vary much from year to year. There seem to be different strains of the disease at different times, and unfortunately in some years the mortality from pneumonia is awful—there is no other word to apply to it. We had a very bad experience of this in London some years ago. In a good year the hospital mortality from pneumonia may be as low as 7 per cent., but in January and February, 1890, it was 64 per cent. This was when influenza was rife and was so frequently followed by pneumonia. Of course, when you are in such a serious year as that you will be very guarded in your prognosis.

Next with regard to treatment. You have to remember, when you are treating a patient with pneumonia, that the disease is a specific fever, and we do not know anything for it comparable to quinine for ague or antitoxin for diphtheria. Of course you will put the patient to bed, and give him a light diet. The question always arises, Shall he have alcohol? In most cases that is quite unnecessary, but the pulse is the guide. If the pulse seems to you to be small and frequent you may, by giving alcohol, try to make it fuller and slower. The disadvantage of alcohol is that you may lose time; you cannot tell for a few hours whether it will have the desired effect, because it is well known that while in fever the pulse is very often slowed and made more regular by alcohol, often this is not so, and then there is a loss of time. But alcohol has the advantage that it also induces sleep. A few years ago it was believed that alcohol was particularly suitable for patients with pneumonia; I have seen a patient with pneumonia taking a pint of brandy a day. I think the prevailing opinion now would be that there was no evidence that such doses were better than any other form of treatment. I said that these patients often cannot sleep, and you can easily see how much exhaustion may result from insomnia. Even you or I know what comparative wrecks we feel next day if anything has kept us from sleeping, and after two nights without sleep the ordinary man is not fit for much. I think the best way to get a patient with pneumonia to sleep is to give him Dover's powder, 10 grains. And I say that advisedly, because you will find text-books which will tell you it is undesirable. I was taught here to give it by those who preceded me; I have given it many times and have never see any harm result. But what makes many withhold it, and therefore put the patient to unnecessary distress, is, they say pneumonia is a disease of the lungs and kills by paralysis of respiration. But that is not quite right, for we should look at pneumonia as a specific fever with a rash in the lungs as it were. And, as we have seen, the patients do not usually die from their lungs, but from the heart. Therefore you may give them opium, and unless the patient is extremely livid it is seldom you come across a case of pneumonia which is not the better for Dover's powder, and I have never seen a case of opium poisoning in pneumonia; not only does opium produce sleep but it relieves pain. Often, especially if the patient is an alcoholic subject, he is delirious, and then it is very difficult to get him to sleep. In such cases paraldehyde may be very useful. Remember that it is very nasty; it is best given with tincture of orange in at least two ounces of water. In a desperate case you may give $\frac{1}{200}$

or $\frac{1}{100}$ of a grain of hyoscine subcutaneously, but it must be given with great care.

With regard to local applications, I think there is usually much more comfort from an ice poultice than from a linseed poultice. Doctors who have had pneumonia, have told me how much better an ice poultice is than an ordinary one. In none of our cases in Clinical has pain been a very great feature; if it had been, we should have put an ice poultice on the chest. Some years ago a question on pneumonia was set for the Treasurer's Medal, and a candidate said he had had pneumonia himself, and until then he had had no idea of the relief which was afforded by Dover's powder and ice poultices.

The next point is, as to whether you should bleed the patient. I think there are some sufferers from pneumonia who are lost, because the doctor does not bleed them. About 1855, you will remember, the "bleeding" controversy was at its height. Then bleeding was given up, and was hardly done at all for some 30 years. Recently we have learned its true position, I hope. But to show you how much bleeding was formerly regarded as necessary for pneumonia, it is only 60 years ago that a doctor was prosecuted for malpraxis because he did not bleed a patient for pneumonia. The sole indication for bleeding in pneumonia is the degree of lividity. If a patient is livid because he has a large amount of lung blocked by pneumonic exudation, I think you may save his life, or at least make him much more comfortable if you bleed him. You need have no fear of bleeding the patient to death, that would never be done nowadays, but you may freely take 15 ozs. of blood from a livid adult. Oxygen is very frequently given, and it is difficult at first to understand why it does any good. It may be because in pneumonia, owing to the short breaths which are taken, the lungs never get rid of air nearly as well as they do in health. The air stagnates in the alveoli. So if the air around the patient is charged rather highly with oxygen it diffuses better into the lung than if the patient has only the oxygen of the air. I admit it is often difficult to see that a patient is any better for having the oxygen, but many patients ask for it. And I well remember one man who, after he was well of a severe attack of pneumonia that necessitated bleeding, was asked what he found did him most good. He said, "I always felt better when I had the oxygen; it was like so much champagne." So I think you can go on giving it.

I have told you that the pneumonia poison kills by the heart; consequently it frequently happens that you are face to face with the problem that you will not save the patient unless you can keep the heart going until the crisis, and if a few days have passed you may always hope that the crisis is near. If you feel you are loosing a case because the heart is failing, the best drugs are certainly digitalis and strychnine. The first is frequently combined with caffeine; and we often use it in the wards with nux vomica; you may give more digitalis than is usually advised. You will not kill your patient with digitalis so long as the pulse remains rapid; the pulse will guide you as to whether you are giving too much. I am sure that sometimes not enough strychnine is given. It is better given subcutaneously, and if I were fighting hard to save a case of pneumonia I should be willing to push strychnine until there was a slight twitching indicating poisoning. In the worst case of pneumonia I have ever seen get better the doctor gave strychnine so frequently that ultimately the patient slightly twitched, but he got well. As in all diseases, when the heart is failing you may improve it very much by a saline injection.

You often find, when you go to see a patient with pneumonia, that he is taking expectorants. Personally, I quarrel with that a good deal. In the first place, expectorant mixtures, which are usually nasty, are almost always made up with syrup, *e.g.*, syrup of squills, and this impairs the taking of food. Who would take a lot of syrup if he wanted to enjoy his food. The drugs usually given as expectorants are carbonate of ammonia, squill and senega, but these are gastro-intestinal irritants and emetics, and surely such drugs are undesirable when often it is difficult to get the patient to take his food. It always seems to me the best way to aid the expulsion of secretion is to try to give the patient strength to cough it up.

It is nauseous expectorants which remind one of the witty saying of Montaigne: "When I am sick . . . . I . . . . answer such as urge me to take physic, that at least they will tarry till such time as I have recovered my health and strength again, that I may be the better enabled to endure the violence and hazard of their potions."

In the next lecture we will consider broncho-pneumonia.

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Wednesday, March 16th and 23rd, 1.30 p.m., Clinical Surgery, by Mr. Symonds.

Saturday, March 19th and 26th, 1 p.m., Clinical Medicine, by Sir Cooper Perry.

Caesarian Section.

Performed by DR. HORROCKS, on March 4th, 1904.

R. L., æt. 41. Admitted to Victoria ward on February 22nd, 1904.

Patient was admitted into Dorcas ward in August, 1899, for obstructed labour. On careful examination the pelvis was found to be contracted, so Dr. Horrocks performed symphysiotomy and delivered a full time child. Since that time she has had one pregnancy and miscarried at the third month. The present pregnancy is calculated to date from June 1st, 1903, when she had her last period. She was admitted on the understanding that a Cæsarian section should be performed, and at the same time she should be sterilised to avoid future trouble.

She expected to attain full time on March 6th, so the operation was fixed for March 4th, provided labour did not come on before. Pelvic measurements taken with the callipers were the following :—

Inter-cristal	- - -	10½ inches.
Inter-spinous	- - -	9½ "
External conjugate	- -	6¾ "
Diagonal conjugate	- -	3 "

On Friday, March 4th, patient having been prepared for operation in the usual way, she was taken to the operating table and put under an anæsthetic. The skin was carefully cleaned and dried, after which the incision was made in the middle line, extending from one and a half inches above the pubis to one inch below the umbilicus. All the abdominal structures were divided to the same extent, and bleeding points caught.

The peritoneum was next incised, and gauze (dry sterilised roll) packed round the uterus.

The next step was to open the uterus; this was done with a knife, the first cut being superficial and marking out the proposed length of the uterine opening; it was then rapidly deepened till the uterine cavity was reached at one point. The placenta was found situated anteriorly and directly over the part incised, so the uterine wall was rapidly divided and the placenta detached.

Dr. Horrocks then inserted his hand into the uterus, seized the child by the leg and drew it out through the uterine opening.

The cord was twisted round the child's head, so it was at once divided and the child delivered.

The uterus was then drawn out of the abdomen through the abdominal wound, and completely emptied.

The organ contracted well and the bleeding, which was scanty, ceased. The uterine wall was then sutured with seven stitches of No. 4 silk, which passed through the whole thickness of peritoneum and muscular wall, but avoiding the decidua. These were at once tied and three accessory superficial sutures inserted where there was gaping of the lips of the wound. Having disposed of the uterus, the broad ligaments were next defined, the Fallopian tube was isolated and an inch of each tube removed, bleeding being arrested by a silk suture inserted into the broad ligament and compressing the cut ends of the tubes.

The uterus was replaced and the abdominal cavity dried. The abdominal wall was closed by eight salmon-gut sutures passing direct through the abdominal wall and peritoneum, and so bringing the cut surfaces into good apposition. The wound was dressed with dry gauze and firmly fixed on with strapping.

The child, a fine looking boy, weighed seven and three-quarter pounds. There are three points of interest in this case :—

(a) The excellent result of the symphysiotomy. She walked well nine weeks after the operation and has had no trouble since, except that the ends of the silver wires used are a little tender.

(b) Dr. Horrocks operated at a pre-arranged time. Labour had not commenced naturally nor was it induced; the uterus contracted very well, however.

(c) The position of the placenta on the anterior uterine wall did not prove a serious complication.

H. D. B.

Notes from Skin Outers.

Eczema.

Eczema means etymologically a "boiling-out," and clinically the term has been used so loosely that the utmost confusion has been caused, as to what is and what is not included under this term.

Those attending Sir Cooper Perry's Out-patients regularly will have noticed how careful he is to distinguish "pyodermia," "seborrhœic dermatitis," "occupation dermatitis," and "sweat-rashes" from what he calls "eczema" itself.

In Dr. Hilton Fagge's time the tendency under Hebra's influence was to widen the range of application of the term eczema; at the present time without a doubt it is to restrict the term, by an eliminating consideration of its ætiology, to an idiopathic, itching, inflammatory, disease of the skin, which presents the following characteristics :—

1. It is *idiopathic*, *i.e.*, has no obvious cause.
2. It is *symmetrical*.
3. The primary lesion is *vesicular*.
4. At one time or another there is a *serous discharge*, which stiffens linen.
5. It tends to *recur*.

It used to be said that about half the cases of skin diseases were eczematous, but in the modern restricted sense it may be put at about a quarter (Radcliffe-Crocker). On one out-patient day at Guy's, taken at random, out of a total of seventy-seven new cases, nineteen were eczema. Generally speaking eczema may be said to have a preference for flexures, and flexor surfaces; it occurs also on the scalp (generally with seborrhœa), the ears (particularly the posterior surface),

the face (where it may have the distribution of lupus erythematosus), the palms and soles (where it is modified by the thick epidermis, and causes painful fissures—this condition is called eczema rimosum. Although the vesicle is the essential primary lesion of eczema, it is rarely present in large enough numbers to constitute the predominant lesion of any particular case; when it is, it constitutes the variety known as—

1. *Eczema vesiculosum.*

2. *Eczema papulosum* is a common and troublesome form. As the name implies, papules are a leading feature. This form is prone to affect extensor surfaces and the back. With a lens tiny vesicles can often be made out on the top of the papules.

3. *Eczema erythematisum* occurs in is most typical form on the face, it consists of red, dull, slightly scaly patches, attended with much heat and swelling.

With an increase of inflammation any of the above varieties may develop into—

4. *Eczema madidans*, where a bright or dusky red, raw, profusely weeping patch is presented. It is most often seen on the legs in the elderly.

On the other hand, in consequence of decreased intensity of inflammation, we have—

5. *Eczema squamosum*, which is seen either as a subtypical form, which never becomes vesicular, or else as a healing stage.

Eczema may be acute or chronic; these terms are used in different senses, they may refer to intensity or duration.

The pathology of eczema is essentially that of inflammation generally. The changes are primarily in the papillary layer, later in the epidermis, and in chronic cases the deep layers of the corium may be involved, when the skin becomes thick and leathery.

As regards the ætiology of eczema, using the term in its present restricted sense, it must be confessed that nothing is known. Radcliffe-Crocker says "Men and women are alike subject to eczema from the first to the last week of existence." The following facts may, however, be noted: eczema is more common in winter than in the summer, a locality drained by varicose veins is more liable to become eczematous, defective feeding—resulting alike in marasmic rickety children, and gouty old age,—has probably a lot to answer for (R. Crocker).

In other words, we come back to "that blessed word" metabolism and its vagaries to explain the situation.

Sir Cooper Perry is of opinion that worry and nervous shock causing malassimilation are the most important factors. And a parasitic theory has been advanced but by no means proved (M. Morris).

With regard to local irritants, it may be shortly stated that the consequent disease should be more fairly termed a "dermatitis" than an eczema.

The treatment of eczema must be dictated by that rarest of all mental attributes, common sense—*and* patience.

Internally treat concomitant constipation (Apenta water before breakfast, a wine-glassful, cascara sagrada, etc.), gout, debility, etc.

Sir Cooper Perry points out what beneficial results follow the administration of cod liver oil and iron in the eczema of old people and young children. In acute cases occurring in the robust, vin. antimon. ♏v., t.d.s. is advocated by Hutchinson and M. Morris. A good prescription is—vin. antimoniatis ♏ vii.; mist. colchici cathart ad ℥j. t.d.s.

With very intense irritation, chloral, sulphonal or even opium may be needed, but the latter must be exhibited with care. In the local treatment two essentials must be always borne in mind.

1. The removal of all scabs by a boric acid and starch poultice, or by loosening them by applying strips of flannel soaked in olive oil. The writer knows of a case where a medical man's career was made by recollecting this simple precaution in treating a royal patient, thus effecting a cure where half the specialists in Europe had failed.

2. The *constant* application and not mere perfunctory dabbing of the surface with the application decided upon. The medicaments applied may be in the form of powders, lotions, liniments or ointments. Generally speaking, liniments are best for acute cases, ointments for dry and chronic.

Liniments and ointments must be applied in strips of lint, lotions must be dabbed on until a good covering is effected, and are best suited to acute cases where the discharge is very profuse. Soothing applications are necessary in acute cases, stimulating ones in chronic. Keeping the above in mind, the following list of applications which may be prescribed is given here:—

For acute cases with less discharge.

Linimentum calaminæ	(G.H.P.)
„ plumbi	(G.H.P.)

For acute cases with much discharge.

Lotio acidi borici...	(G.H.P.)
„ calaminæ	(G.H.P.)
„ plumbi	(G.H.P.)

For cases with VERY *little or no discharge and for chronic cases.*

Pulvi acidi borici co	(G.H.P.)
„ zinci et amyli	(G.H.P.)
Unguentum ac. borici co	(G.H.P.)
„ bismuthi co	(G.H.P.)
„ bismuthi oleatis	(G.H.P.)
„ calaminæ	(G.H.P.)
„ diachyli	(G.H.P.)
„ glyc. plumb. subacet	(B.P.)
„ hyd. ox. flav.	(B.P.)
„ metallorum	(G.H.P.)
„ oleatorum...	(G.H.P.)
„ plumbi carbonatis	(B.P.)
„ zinci	(B.P.)
„ zinci oleatis	(B.P.)
„ zinci with bismuthi	(G.H.P.)

If an eczema be complicated with a pus infection *always* prescribe a mild mercurial ointment (Sir Cooper Perry).

In all cases of eczema, things to be avoided are undue exposure to air, and the indiscriminate application of soap and water.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Present System of Treating Fractures.

DEAR SIR,—In your issue of the 13th of February you have a paper from Mr. P. A. Peall on "the present treatment of Fractures." You will observe that the designation is too wide. The only fractures alluded to being those (simple, I presume) below the knee and the so called "Colles" or others of the forearm.

It will occur to everyone that these fractures are so easily adapted for massage during treatment that the matter may be accepted at once. What would Mr. Peall say about fractures of the femur and humerus. Are these equally easy of massage at early dates?

It seems to me that they are not, and that the old style of treatment must be accepted for much longer periods before commencing systematic rubbings or movements.

As regards the immediate application of plaster of Paris cases or bandages, I should like to raise an objection, founded on the difficulty of avoiding undue pressure. Also may I remark that the "three man" treatment belongs to hospitals and not to private practice.

I think I am correct in saying, that the most able surgeon cannot tell whether a plaster case may not require to be opened in less than twelve hours. If on opening, there are signs of pressure leading to pain or tissue damage, what advantage has the patient received?

The subject of the treatment of fractures of the long bones, in spite of its well-worn character, is still of the greatest interest, and I should like to see more remarks on it. Possibly, I am wrong, but I think the new ideas put into modern surgical books are likely to cause much disappointment.

Underlying all postural treatment, there should be an intelligence on the part of the patient, which the majority of hospital cases are not likely to possess. What, for instance, would become of a fractured humerus bandaged to the side and unsplinted?

These pretty ideas, at least, should be put only as alternatives, and not as well-tried methods. In all these fractures, I feel sure that the two essentials are; firstly, to support by light splints the immediate site of the fracture, and secondly, to immobilise the limb, especially the articulations above and below.

These are the prime indications, and massage should be used at suitable times. In private practice, fortunately, we are able to attend to many cases long before delay has added to the trouble, and the results are generally highly satisfactory.

A well educated Guy's man ought to be able to put up a fracture anywhere at a moment's notice. Given the principles, the rest must follow.—Believe me to be,

Yours faithfully,

Wadhurst House,
Newington Green, N.,
1st March, 1904.

GEO. T. W. STEVENS.

DEAR SIR,—In reply to the above letter to the GAZETTE, I am very pleased to see that my paper has called forth an answer from an old Guy's man, who has —what we students of necessity lack—years of clinical experience in private practice.

Dr. Stevens does not seem to remember the fact that I was treating a very extensive subject, viz., "the present *system* of treating fractures," in the very limited time of 30–40 minutes, and that during that time I could only take examples to prove my points. I naturally chose as examples the two fractures most commonly met with, and following which bad results are so often seen.

In my paper I wished to give that prominence at our hospital to the general treatment of simple fractures by massage and early passive movement which, in my opinion, it ought to occupy, and the principles I mentioned in the detailed account of the treatment of Pott's and Colles' fractures on these lines I wished to be applied to all cases of simple fractures. Unfortunately, in going to print a paragraph was omitted from the paper, which ran as follows:—

"The two fractures which the dresser finds himself most often called upon to treat are—

1. Pott's Fracture.
2. Colles' Fracture."

"I will describe the treatment of these fractures in detail, but it must be fully understood that what is said about these fractures applies equally to all fractures; one point should, however, be remembered, viz., that the nearer a fracture is to a joint the earlier should massage and passive movement be commenced."

I did not see the proof, and so was unable to correct this omission, but I had hoped that the gist of the paper would suggest that I was advocating a "system" of treatment, and not only treating two simple fractures.

Dr. Stevens, after accepting without reserve this treatment in the case of Pott's and Colles' fractures, and I naturally suppose appreciating the advantages derived from it, questions the same "system" of treatment in fractures of the humerus and femur, because he says it seems to him they are difficult to massage. He does not say whether he has actually met with difficulty in pursuing this treatment in fractures of those two bones, for if so, I can only say that my experience is not the same as his. I have never encountered any difficulty in treating fractures of the humerus or femur by massage and early passive movement; in fact, I am convinced that the only hope of obtaining a useful limb in fractures of the humerus involving the elbow-joint is by this treatment. I have seen several cases of separated epiphyses of the lower end of the humerus treated in the method I advocate with perfect results.

With regard to fractures of the humerus treated by bandaging. This method, combined with an axillary pad, I have employed in three cases of fracture of the surgical neck of the humerus. In each case the wrist alone was supported in a sling, massage commenced with great benefit the day following the accident, passive

movement in two of the cases during the first week and in the other on the tenth day. These three patients were as comfortable as one could possibly expect, and the movement in the arms by the time union had occurred was nearly normal.

In answering Dr. Stevens' objection to a Croft, I can quite understand that three men are difficult to get in private practice, but I do not necessarily mean three medical men—one practitioner with two intelligent assistants ought to be able to manage. In this hospital several good Crofts have been put on by two dressers alone.

If one remembers that a Croft consists of two side splints moulded to the leg, and realises that it is only necessary to roll the starch bandage on to the splint without drawing it tightly anywhere, then there should be no difficulty in avoiding undue pressure. Should pressure symptoms ensue, and the splint have to be cut up, the fracture is still well protected and steadied by two very efficient side splints which are now held together, only not as closely as before, by an ordinary bandage instead of the starched muslin bandage.

Without doubt any Guy's man can put up a fracture at a moment's notice, but what we want to do is to restore to the patient the full use of the injured limb in the shortest possible time.—Believe me, yours sincerely,

PERCY A. PEALL.

Pass List.

University of London, January, 1904.

PRELIMINARY SCIENTIFIC EXAMINATION FOR INTERNAL STUDENTS.

Chemistry and Biology.—*A. N. Leeming.

Biology and Experimental Physics.—J. Pyrce-Davies.

Biology only.—*P. Hirschbein, *W. S. Kidd.

*These Candidates have already passed in Experimental Physics.

PRELIMINARY SCIENTIFIC EXAMINATION FOR EXTERNAL STUDENTS.

Biology.—*H. I. Janmahomed.

*This Candidate has already passed part of the Examination.

GENERAL INTERMEDIATE EXAMINATION FOR INTERNAL STUDENTS.

G. F. E. Allison, S. W. Daw, P. D. F. Magowan, R. J. Reynolds, E. Wragg, A. Zorab.

SPECIAL EXAMINATION IN ORGANIC CHEMISTRY ONLY FOR INTERNAL STUDENTS.

S. H. C. Air, L. T. Baker, M. E. Ball, C. A. Basker, S. S. Brook, T. E. A. Carr, M. M. Cowasjee, L. Croft, A. F. W. Denning, K. H. Digby, E. W. Giesen, H. J. Henderson, E. L. Mandel, J. B. Martin, C. A. L. Mayer, W. P. H. Munden, H. E. Perkins, M. D. Price, M. J. Rattray, J. T. Smalley, H. J. Smith, G. F. Stebbing, H. Stott, St. J. A. M. Tolhurst.

INTERMEDIATE EXAMINATION IN MEDICINE FOR EXTERNAL STUDENTS.

A. Alcock, G. B. F. Churchill.

SPECIAL EXAMINATION IN ORGANIC CHEMISTRY ONLY FOR EXTERNAL STUDENTS.

S. Chelliah.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. J. S. Cooper, R. A. Greeves, F. P. Hughes, M. G. Louisson, G. A. Ticehurst, E. L. Ward.

Obstetric Dressers.—Messrs. F. M. Longson (April 1st); R. W. Allen (May 15th).

Dressers in the Throat Department.—Messrs. G. Carlisle, H. H. Jenkins, J. Mc F. W. Pollard, A. R. Brailey, W. M. Mollison, F. W. Morton Palmer.

Assistant Surgeons' Dressers.—Messrs. C. M. Ockwell, L. H. Burner, W. H. S. Burney, T. F. Wilson, P. S. Mills, S. Reader (Mr. Lane); G. N. Bartlett, E. M. Harrison, E. C. Lowe, H. F. Vandermin, A. S. Morton Palmer, C. F. Fothergill (Mr. Dunn); H. G. Gibson, G. Wacher, A. G. Jones, P. C. Litchfield, J. H. Mayston, T. R. Harvey (Sir Alfred Fripp); R. M. Wingent, I. R. Cook, E. Alban, A. W. Berry, C. C. A. de Villiers, G. H. Morris (Mr. Steward).

Medical Ward Clerks.—Messrs. T. H. Barton. A. W. Eyles, J. S. Bookless, W. Welchman, W. H. Trethowan, A. S. B. Bankart, E. Morgan, W. H. Robinson, A. Walker, C. Ponder, A. Shepperd, G. Cockcroft, P. D. F. Magowan, I. Valerio, H. C. Malleson, R. Willan, R. Davies-Colley, G. W. Goodhart, F. A. Barker, C. W. Greene, H. J. Clarke, J. A. von Wiehe, J. G. Phillips.

Surgical Ward Clerks.—Messrs. J. E. Hodson, T. B. Layton, A. Zorab, W. R. Greening, J. L. Rankine, O. G. F. Luhn, G. R. Phillips.

Clerks in the Skin Department.—Messrs. A. S. B. Bankart, H. M. Clarke.

Aural Surgeons' Dressers.—Messrs. B. W. Lacey, A. R. Brailey, E. C. Myott.

Post-mortem Clerks.—Messrs. R. Felton, A. Leeming, G. H. Rees, C. J. S. Dismorr, E. C. Hughes, C. M. Stevenson, C. M. Wenyon, T. Turner.

In Lighter Vein.

AN EVENING WITH THE DEBATING SOCIETY.

"Satis eloquentiæ sapientiæ parum."
(Motto of G. H. D's.)

A MOST interesting meeting took place on Saturday last in the Smoking Room of the College, and although the results were fraught with unhappy consequences for the speakers, yet for the majority, who took no active part in the proceedings, the evening was amusing enough.

Several Sisters and Staff Nurses were present, and these made the dingy old room seem like some fairy palace, so marvellous is the effect of feminine personality. There were also other lady visitors, less imposing in appearance, but equally effective in a graceful and unassuming way.

The subject for debate had not been announced, and considerable curiosity was expressed on all sides, until the President, Dr. Savage, solved the problem, by announcing that the motion before the House, was "That there is nought so queer as folks." This subject, he declared was a most interesting one, and since the speakers for the evening had all been carefully chosen, he did not doubt that the House would carry the motion by an overwhelming majority.

The first to spring to his feet was Mr. Goble; he said that his speech was so important that he would have to come into the middle of the room to get rid of it. When he had reached the middle of the room, he opened his mouth to say something, but remembering that he could not speak, for "little apples," he changed his mind and returned to his own place.

Mr. THOMPSON next arose. It was noticed that he was wearing a frock coat and a fancy waistcoat. He said that there was absolutely no need for him to change his place, for he both could and would make himself heard anywhere. In spite of the fact that he always looked and spoke as though he were in a furious temper with everybody, yet he found that he never did more than raise a smile from the meanest ward clerk. If the House could explain it he would be very much obliged. As for Messrs. Rose and Carless he considered . . . (Loud uproar during which the speaker resumed his seat in a state of suppressed fury.)

Mr. GRIFFIN, who followed, explained that the House owed the pleasure of his company to the leniency of the Camberwell House authorities. He was suffering from the strangest obsession that ever was heard of. He had some time ago become the proud possessor of a toy, in the shape of a small, pliable, indiarubber face, and from long contemplation of the same he had come to notice the likeness it bore to his own physiognomy, until now he was sure that it was a reflection of his own and that its pliancy was a symbol of his own capability for mental gymnastics. Nothing that anybody could say would convince him to the contrary. (Laughter and applause, in which the speaker joined.)

Mr. WATNEY delivered a speech in his well-known style. He said that a legend had got about to the effect that he was one of the secretaries of the Debating Society. He could not understand how so foolish a story could ever come to be believed, and he was certain that he had never done anything to deserve it. It was true that he sat at the secretaries' table, but that was only in his ornamental capacity. (Coughing and mirthful noises.)

Mr. BRYDÔNE, whose moustache was noticed to have grown of late, said he came from Welbeck Street. (General surprise). Like most of the streets where medical men most do congregate, it was rather a dull place, but he employed his time in writing to the papers, and this relieved the tedium of off hours.

Mr. MYOTT read a long extract from one of his favourite novels, insisting in dulcet tones on the love passages. He spoke in a sympathetic voice, and smiled sadly at every full stop.

Mr. BLACK said that it was the first time for years that he had not spoken at a debate. He would probably never miss another.

Sister WHEEZES spoke of the Nurses' Debating Society; they were hoping before long to discuss whether or no a recent letter in the GAZETTE was correct in its description of "the sister."

This subject was at present exercising the attention of the nursing staff.

Dr. SAVAGE, who was received with cries of relief, said that he had always thought that there was no such thing as insanity until he accepted the Society's Presidential Chair, but since then he had had his doubts. He proceeded to put the motion to the vote—"That there is nought so queer as folks." It was carried by an overwhelming majority. The speakers were then persuaded by the President to accept the hospitality of a certain well known "retreat" until such time as they should be better fitted to again take part in the battle of life.

THE DAUNTLESS THREE.

The Physiology of Pain.

A paper read before the Guy's Hospital Physiological Society, by Mr. J. L. RANKINE.

Mr. PRESIDENT AND GENTLEMEN,—That attribute of human life—Pain—which has occupied the attention of philosophers since, we may say, the first rise of serious thought, has never yet received a satisfactory explanation. In a great measure it has escaped the attention of physiologists who seem to have been too much occupied with the smaller types to notice what was writ large before their eyes.

This important phenomenon has been treated from various standpoints; it is important, because, as I hope to show you, it is one of the chief, if not the chief of the factors promoting the evolution of the higher species from the lower; in addition the higher species, by its aid are able to maintain their own level and to attempt further advancement towards the higher ideal ever before the human mind. Philosophers, arguing as with all subjects only by logical reasoning from ideal premises, sought in metaphysical reasons the cause of pain: by comparing pain to pleasure, they endeavoured to arrive at its solution. We need not go any further into their reasonings for the argument of itself falls to the ground, as they only explain one obscure thing in terms of one still more obscure. Some even tried to prove that the so-called sensation of pain was a non-existing quantity; but we can imagine the sensations and perhaps the utterances of the philosopher living in his theoretical painless world, who had to grope for the door when the light suddenly failed.

The religious-minded looked upon pain as a heaven-sent punishment for mortal sin; and upon that view have been founded some of the most curious sects modern times have seen—faith-healers, Christian scientists, etc. To the latter reference will be made later on.

Physiologists, when they did turn their attention to the subject, approached it in a much more practical manner, and have propounded many theories each of which in the usual way had to give place to a newer, till at last we have only two main theories to deal with.

While both schools agree in the definition of pain as a sensation the recurrence of which we seek to avoid on all future occasions, they are diametrically opposed in their explanation of the phenomenon.

The greatest obstacle met with in the study of pain, is our inability to penetrate into the thoughts and feelings of others; the only means we have of judging whether or no pain is present, is by the convulsive movements of the subject under examination. Even here the difficulty of determining what movements indicate pain and what do not, confronts us; as, if two animals be taken, in one of which the brain has been destroyed, the same stimulations cause the same movements in both animals, and if strong stimuli be used, the convulsive movements, cries, and attempts, either to flee from the irritant or remove it, are identical in both cases. In a word, how are we to distinguish between mere reflex action and the actions associated with pain? That, gentlemen, is a question to which I defy any man to give an answer. Can we not say that consciousness and consciousness to pain have two relative bearings? Firstly, in regard to that indefinable something which in our ignorance we call "self" and whose home we place in the brain; and secondly, in relation to each individual cell which goes to make up our entity? In that idea lies, I think, the explanation of all those convulsive movements which at present are our only criterion of another's pain.

With that we may pass to the consideration of the theories. The one school contend that there is a special set of nerves for the perception of that which we call pain.

Histologists have found various terminations for nerve fibres, and to them they assign the property of conducting various sensations, and to that the fact of finding so-called heat and cold spots in the cutaneous surfaces; and there we have the only basis for the support of this theory. What that amounts to is this, that for each particular sensation there is a particular nerve ending, and consequently a nerve fibre and further nerve cell and station in the brain to which, as to a headquarters, the disturbances at the periphery must go for interpretation. That is said to be an anatomical impossibility. For we have multitudes of different sensations each of which is quite distinct, and very few merge imperceptibly into others, and so on this theory we must necessarily have corresponding fibres, which is clearly impossible.

Dealing alone with pain, the different kinds of stimuli which can cause pain would connote an equal number of nerve fibres capable of transmitting those sensations; that also must be considered impossible. Of the arguments in favour of this theory we may cite the fact that in any cutting wound, sensation precedes pain, that is to say that one gets the impact of the instrument—even its temperature may be noted—at a distinct interval before

the sensation of pain is felt. This interval is so distinct that it can be measured and has been found to vary from a fraction of a second to a second. To this fact I shall refer when showing you the second theory. Also patients who have been anæsthetised for an operation, say that while they have had absolutely no sensation of pain, yet they have distinctly felt the edge of the knife when it was applied to the limb, and some have even said that they have heard a sawing noise when that instrument was used in amputations. Here again we find another fact in support of what I have expressed above of the relativity of pain to "self" and constituent cells; we see the same convulsive movements in the limbs of a patient under chloroform as we should see in another or in the same patient if no anæsthetising agent were employed. Other arguments in favour of this theory are, that in certain diseases sensation of pain is lost while sensation in the ordinary sense is still existent, though modified to a great degree; and conversely, that in certain other diseases pain is greatly intensified while ordinary sensation is lost. I propose to leave the discussion of these also till we come to the rival theory.

The greatest objection to this theory of there being special nerves for the sensation of pain, is that stimulation must always be of a retained, definite kind. Taking heat and cold alone, we are to believe that there are certain nerves for these two sensations, but can we truthfully say that we have separate painful feelings for intense heat and intense cold? Again, if that be not the idea, if pain and pain alone be recorded by these nerves, then in that case there must be a certain amount of stimulation which causes that pain, the alterations in intensity, etc., being caused by the strength and duration of that stimulus. Here one may ask, Why it is that a certain strength of stimulus applied to one spot produces pain, and in another will produce only the sense of touch connected to the kind of stimulus employed? We cannot go on dividing the nerves ad infinitum, that is to say, first into nerves of pain, then into classes denoting a certain strength of stimulus, and so on. So that, gentlemen, this theory, in the light of facts, of itself falls to the ground.

The other school propounded the theory that the sensation of pain was entirely dependent upon a certain constant vibration in the component parts of the nerve fibres, and that when that vibration was above the normal it resulted in pain, the intensity and duration of that pain depending directly upon the intensity of the vibration and its duration. This theory, if not accepted as being nearest the truth, has at least the merit of bearing out to some extent the atomic theory and a merit perhaps even greater than that, viz., simplicity. Here we do not force on the already complicated human anatomy, a further complication of special nerve fibres each with its own special function, but we have only to deal with one set of fibres and those entirely devoted to sensation. As a preface to the theory we may suppose, and here there is no contradiction, that the essential conducting part of the nerve fibres is made up of a number of fine atoms vibrating to a certain fixed rhythm, one may even call it a certain fixed note. Any factor acting in such a way as to increase or lower that vibration will produce another rhythm or another note, the result of that change being translated by some means [about which at the present time we are unable even to theorize] in the brain into the conscious sensation. At what we may call the resting stage, no sensation is perceived though the rhythm goes on; we may assign as the reason for lack of sensation, that the particles are in consonance with the rhythm of the component atoms of our brains and of the world external. Now, if the atoms be made, under stimulation, to vibrate in a manner different from the normal, let us say faster, for the sake of argument, the result is a sensation in some form or another. Now let us apply various stimuli to the body to test this idea practically, and of all stimuli the most convenient is electricity. A slight induction shock produces mere sensation, but if the current be gradually increased—and here notice that the nervous atoms increase in vibration progressively with the intensity of the stimulus—we pass through all the stages of discomfort to tolerable pain up to agonizing pain. The same happens if weights be put upon the hand, slight weights cause mere sensation, but increasing weights put us through all the stages up to absolute torture; the final stage is so great a vibration that exhaustion supervenes, that nothing at all is felt, *i.e.*, loss of consciousness results. In passing, we may say that pain may be caused otherwise than by an excessive stimulus, and the phenomenon is comparable to the effect of summation of stimuli or the tetanus seen in muscle preparations. A very small electrical stimulus once applied will cause mere sensation, but if repeated constantly for any continuous length of time, will end by producing acute pain. We have direct proof given us by the exploits of the "pillars of the church" in the Middle Ages. Really it seems as if these delightful persons had made a special study of the human nervous system, in order to calculate how much torture they could inflict without actually killing their victims. To them must be ascribed the merit of having discovered this interesting fact of summation of stimuli. They found that while one drop of cold water let fall upon the skin produced only sensation, a continued dropping caused the most exquisite torture. Incidentally we may remark that this is direct proof against the special nerve theory, as the only effect that the water could have in that case would be merely a sensation of cold; pain would not come in at all. On this theory all kinds of pains can be explained, from the shooting rapid sensation to the dull aching pain long continued. The shooting pains of toothache can be explained by the theory that this stimulation, resulting in increased atomic vibration of a certain strength, wears out the vital properties of the nerve to such an extent that for the time being the nerve becomes exhausted and then it recuperates; after recuperation, vibration can be again set up if the source of stimulation be still present—hence the rapid shooting

pain. The dull ache can also be explained by saying that the stimulation is less intense and so causes less vibration in the nerves, but that that vibration continued for a length of time is not inconsistent with the steady life of the nerve fibre. With this theory we can explain many of those peculiar phenomena of human life upon which by the opposing theory no light could be shed. There is a state of mind—we can call it a nervous state—produced by too long occupation in one groove for which the only cure is to leave that rut and seek fresh sights and sounds elsewhere. That state has been called "ennui." It can be explained by the vibration theory. We see a person living in one groove for a long time; the whole nervous system becomes tuned to the notes, or rather note, of that particular groove and ennui results, just in the same way that one tune played over and over again would produce ennui in the minds of the hearers and would drive them to seek a fresh tune elsewhere. So the nervous system of these people suffers by having one note rung upon it often and long; and they must, to obtain relief, go elsewhere to find different notes and stimuli to produce different vibrations in their nervous systems. If this were more widely recognised, perhaps the majority of those prudes who have nothing to show for their own lives, would be more lenient to those who seek to bring their nervous vibrations to a happy medium by playing off new notes against that note of ennui.

Two diseases have been advanced in support of the opposing theory, viz., that insensibility to pain together with sensation to touch is the result of some diseases, while of others the converse is true: these two cases can both be satisfactorily explained by this atomic vibration theory. For we can see clearly in the one case, that some factor connected with the disease acts upon the nerve fibres—probably by way of the blood supply—by decreasing the vital properties of the nerves in regard to their vibration capacity, and acts upon them in such a way that they cannot be set into a vibration greater than that corresponding to the note or rhythm of sensation. Conversely in the other case, that they cannot decrease their vibration to the note of sensation, so that any stimulus added must result in the sensation of pain; in other words, in this particular disease they are set to a note higher than that corresponding to the note of mere sensation.

Again, by the theory of special nerves, we would necessarily have sensations of pain of such a character that all would be different in kind as well as in intensity. A little thought will show this to be entirely contrary to the facts. Consider pain as pain alone, without bringing in any ideas of its effects or causes, and we see clearly that all pain, resulting no matter from what stimulus, is identical: in fact it can only vary in intensity and duration. For example, take the pain from a sharp blow on the skin and that resulting from any inflammation, say appendicitis; if a certain definite moment of time be taken, the two pains will be found to be identical in character; in fact, all that one could say would be that pain was present; destroy the time limit and then the nature of the pain as regards intensity and duration becomes apparent. This cannot be explained by the "special nerve" theory at all satisfactorily, but is at once easily comprehensible by the "atomic" theory.

Another point I shall try to disprove to you is that pain can be remembered. It is stated in some books that pain can only be useful to us in that it can be stored in the memory for future use. That, gentlemen, I would have you doubt. We have seen how pain was caused by a state of hypervibration—that word I use to mean a state of vibration greater than the normal, in the component atoms of the nerve fibre, and how, necessarily, that state ceased when the stimulus ceased. Now it seems to me that the question can be resolved into this: Can the brain, as the centre of consciousness, excite of its own free will this state of hyper-vibration? To that I think an unqualified denial must be given. On economic grounds we must deny it, for if we could recall to our minds the state of pain that took place previously, I think we should never be without pain. A merciful providence has denied that power to us. Some have said that we actually do remember pain in itself and can recall it to mind, and this I have already told you has been regarded as the main use of the sensation. But, gentlemen, I would insist that all we can and do remember is that we suffered pain; we could describe the nature of the injuries that caused it; we could tell the circumstances and agents that brought it about; we could even hint at its nature and compare it to some other equally indefinite sensations, but beyond that nothing. Surely that is quite enough to enable us to recognise those circumstances and agents again, and to enable us to ward off their consequences, in a word, to give us the means of avoiding a like sensation in the future.

Surely, too, this theory of vibration goes far to explain the question: What is pain? The special nerve theory can only show us how pain is caused, *i.e.*, by stimulation of special nerves, while we can, on the other theory, at least go a little further than our first definition of pain as a sensation, a recurrence of which we avoid on all future occasions. We now can say that the essential part of that state we call pain, is nothing more or less than a vibration of our atoms in discord with the vibration of the component atoms of the universe. As to how we are enabled to recognise that such is the case, I have been unable to find even a theory; that merely amounts to a confession of my own feebleness. Psychology gives one, I am told, but the co-ordinated complexity of their associated ideas in regard to the relativity of feelings and the correspondences in totality &c., &c., produced such a mixed oscillation of my till-then applied attention, that my bearings became abstract and I made a strategic movement to the rear.

With these few facts I will conclude the consideration of the physiology of pain and shall leave you to judge between the theories; whether the phenomena of pain can be better explained upon the theory of a special set

of nerves or by what I would call the "atomic vibration theory."

Now we must seek to know what is the use of pain, why do we suffer it, when according to some thinkers we could very well do without it.

Firstly, from a medical point of view, there can be no doubt as to its use. Without pain of some sort, diagnosis would almost always be at fault; as a result of the non-existence of pain we should have the pleasing sight of people going to be examined at certain regular intervals, to see if any part of the gear was not in proper working order. With it, disease can usually be localised to certain definite areas or organs. That point, as you all know, has been thoroughly worked out by Mr. Hilton and Dr. Head. Knowing the distribution of the nerves of the body and the law relating to peripheral sensation, they were able to follow them up and find out the real seat of injury, though that was often far from where the pain was felt. Here, again, we are met with facts which cast the shadow of doubt upon the best theories; why in certain diseases is pain found at a part of the body in, so far as we know, no direct nervous relation to the parts affected? The resolution of that question I leave to my seniors. Another most important medical point in connection with pain is that it directs the attention of the organism to one point, and, in so doing, must materially help Nature in her processes of cure. That does not mean, however, that attention of the mind can cure the causes of pain as the Christian scientists think. It simply performs its function in calling the attention of the sufferer to the part affected and enables him to take measures for the eradication of the cause. However, is it not an acknowledged fact that mind has a great influence upon the course of a disease? Do we not see hysterical persons, with nothing really wrong with them, suffer and present the same symptoms as those suffering from the real disease? This question of hysteria is so closely allied to hypnotism that I am tempted to try to give you an explanation of the two phenomena. A hysterical patient is in the beginning somewhat of a neurotic type; something occurs, no matter what, which tends to give them an idea; in the course of time they become impressed with that idea, they talk about it, their friends become sympathetic and condole with them, and finally they end by giving them the worst possible advice, viz., "Go and see a doctor." By that I mean that if in the first place their ideas had been laughed at or their friends had talked them out of their absurd fancies, they would not have reached the stage where the worst possible advice was given. I said worst possible, because it adds the necessary external stimulus needed to develop them thoroughly into hysterical patients. How far these persons really suffer pain will probably never be known; some say they suffer acute pain, but in many cases that may be put down to simple malingering and will sooner or later be exposed. In other cases only a theoretical explanation can be given; it seems as if a controlling influence over certain stations in the brain was removed for a definite period, resulting in a state of chaos for the isolated part, but why that part should enter into what we may call convulsions, ending in complete exhaustion, cannot be satisfactorily explained. But there certainly does seem a power in some highly nervous people, over-civilized we may call them, of cutting off the directing part of their inner selves and freeing it, so to speak, from the trammels of the body, that we see has been effected in some forms of hysteria and it is claimed to be within the power of hypnotism to produce the same result. In hypnotism, it appears to me, that the directing power, that is to say the "self," becomes eliminated. I suppose that this is brought about by fatigue or overstrain, since as we are clearly made to understand, the hypnotic state is preceded by a period of great concentration upon some one object. The self becomes eliminated then, and so produces a state where all actions of the subject are reflex, consequently pain is not felt, seeing that the "self" is absent or rather paralyzed for the time being. Hypnotism, however, is not the only factor which can produce a temporary absence of that "self" which takes cognisance of all states of the body. Great excitement, *i.e.*, the intense application of the thinking mind concentrated upon one object, holds such a sway over the sensations of the body that peripheral sensations do not receive attention at headquarters. Soldiers do not notice unimportant but painful wounds during the excitement of battle, but the moment the abnormal state is taken away, the pain is felt; that is to say that the mind can then take cognizance of its immediate surroundings.

Gentlemen, pain has been called an abomination, and an entirely unnecessary adjunct of human life. That idea, taken in a higher sense, I should like to disprove to you. Experience is only bought by pain in some form or other. We recognise the circumstances which caused it, we store them up in our memory and use them to aid us in combatting a similar recurrence in the future. Our whole lives are bent upon seeking the means to avoid pain in all its forms. These means have been variously estimated in different ages; we have seen those who so ordered their daily lives that nothing but pleasure resulted therefrom, those who shunned the "maddening crowd" and the world around them to find perfect pleasure in solitary painless uselessness; and those who spend their energies in accumulating wealth to enable them to avoid physical pain in surrounding themselves with every luxury that money can buy. There we see how far-reaching an influence pain has had. We have learnt the lesson pain has taught us—imperfectly it may be—but we have learnt it. Our whole civilization is the outcome of pain; even we as a type were evolved by the influence of pain, the pain that the struggle for existence entails.

It would be as well to state once more in terms of our theory, that pain is the vibration of our component atoms in discord with that of the universe and that pleasure is to be found in their complete harmony. Civilization strives to bring that harmony to pass, but

will, it is to be hoped, never succeed. That brings me to the last point, the influence of pain on thought, and on that I will not detain you long.

Philosophers and religious men of all ages have propounded each their own Utopia: where life existed in the eternal bliss brought by eternal peace. Recognising the impossibility of such a life on this earth, they laid the scene of our future bliss—almost all have believed in a future life—in an unknown world far distant; but all, by refusing to admit pain, have reduced that life to a nonentity. We have to go to one of the less known philosophers to find a livable future life—in a word to Buddha. He thought of his future life, or rather lives, as a progressive series, in each of which thought and action was of a higher type, but pain was the stimulus to that higher creation. That, gentlemen, would be a livable life, for there pleasure would be known, because there can be no positive without its corresponding negative. In all the other Utopias life would be a mere unthinking vegetable existence, a prelude to total extinction, because there would be no standard wherewith to judge thought or feeling. The results of such a life would be disastrous and would lead to a steady degeneration.

"An early stage of that degeneration," says Mr. Hearn in his book, *In Ghostly Japan*, "would be represented by total incapacity to help ourselves; then we should begin to lose the use of our higher sense organs; later on the brain would shrink to a vanishing pin point of matter; still we should dwindle into mere amorphous sacs, mere blind stomachs. Such would be the physical consequence of that kind of divine love which we so lazily wish for. The longing for perpetual bliss in perpetual peace might well seem a malevolent inspiration from the Lords of Death and Darkness. All life that feels and thinks has been and can continue to be, only as the product of struggle and pain, only as the outcome of endless battle with the powers of the Universe. And cosmic law is uncompromising. Whatever organ ceases to know pain, whatever faculty ceases to be used under the stimulus of pain, must also cease to exist. Let pain and its effort be suspended, and life must shrink back first into protoplasmic shapelessness, thereafter into dust."

Sport.

Rugby Football.

Guy's v. London.

This match was played at Richmond on March 9th. Guy's started from the Richmond end and a scrum was formed at once in the London twenty-five. A good passing rush ended in Morgan being collared; later he kicked over the line and forced a touch-down. Harrison returned the kick-out, but failing to find touch Gibson kicked to half-way. London tried to pass but our three-quarters downed them well and dribbled to the twenty-five. After scrambling play Morgan kicked over again. After the kick-out Guy's forwards carried some scrums well, but Cutler fumbling behind let London get the ball, and by some good passing they reached our twenty-five. Cutler got the ball, and kicking found touch well up the field. From a scrum on the London line Alcock tried to run through but was collared. Harrison made a mark, and Tolhurst had a shot at goal but failed. About this time Guy's made another good passing rush, but Morgan was collared as he tried to cut through. From the scrum Harrison found touch near the goal-line. McEvedy received a pass, and kicking over the goal-line Tolhurst touched down but was given off-side. The Guy's forwards were playing very well, but twice in succession London touched down through too hard kicking. Grogone made a mark and found touch about half-way. London made two good passing rushes but were stopped each time by the good collaring of our three-quarters. Our forwards came away well, and Alcock dribbled to the London twenty-five, where he was collared. Another minor was conceded to London, this time by Cutler, who kicked too hard. Grogone ran to beyond the half-way, and a free kick to Guy's for off-side relieved the pressure. London were now pressing hard, the ball coming to them from every scrum. However, the three-quarters missed good chances by dropping the passes. Cutler kicked from a scrum to their twenty-five. Then a good London rush was spoilt by the collaring of Jones, McEvedy and Morgan. Half-time was called with no score.

From the kick out, Harrison returned to the half-way line, our three-quarters had another chance, but running straight across, Morgan was bowled over into touch. Lloyd kicked to half way, but some good collaring and kicking by Jones once more gave us an opportunity to attack. Saunders was badly off side and gave them a free kick; he, however, got the ball from the line later and kicked to half-way. Alcock, who had had very little to do, at last got a pass and got well down the line, but was collared by Beale. Guy's got the ball and passed, but McEvedy was collared with it; Oakley then got away and ran right through, being well collared by Louisson in our twenty-five. Jones and Alcock missed their three-quarters and took the ball to half-way, here a good forward rush was spoilt by Tolhurst kicking over the line. After the kick out, Jones returned to the full back, who was missed by Louisson. From a scrum in the London twenty-five a good passing rush was spoilt by McEvedy being collared again. Morgan missed Beale who ran along the line and passed to Scott, who gave the ball to Iles, the last named, in good time, transferring to Gibson, who grounded under the posts; Gibson goaled. After this, the game was very fast, the London men putting in some good kicking. Lloyd kicked, and after some scrambling play by the forwards, Gibson received the ball and dropped a goal from about the twenty-five. London nine points. Soon after the kick out, Harrison had a good drop at goal, and they touched down. From the scrums, London now got the ball every time, and their three-quarters had good opportunities, but kicked across the line, Harrison touching down. Morgan tried hard to get through by a dodgy run, but was collared by Oakley. Pinching and Saunders dribbled down the field, and after some even play, no side was called, with London 1 goal and one dropped goal (9 points), Guy's nil.

Remarks.—The forwards played as well as they have played this year, until the last quarter of an hour, when they went to pieces as well as the outsides. In the first half of the game they heeled out the ball well, and got it as often as the London men. In the second half they seemed to tire, and London got it more often. In the loose they were good, but twice Archer kicked too hard in a rush. Once while just in front of our goal straight into Gibson's hands, and he dropped a nice goal, none of our men being near him. The other time Archer kicked over the goal line and so we lost a chance. The fault on our

side lay with the halves. Their passing was very slovenly, and so gave the opposing three-quarters time to get on to ours. They did not drop on the ball as well as usual. Cutler kicked too often and very rarely found touch, and from one of his kicks Grogone nearly kicked a goal from a mark. Jones and McEvedy were not good at offence, they held on to the ball too long, and so Morgan and Alcock were too well marked to do any good. Neither of our wings were as good as usual. They all were good at defence. Jones did some beautiful tackling, always catching his man just below the knees. Harrison was quite good, and was one of the few men on our side who did himself justice. He saved several forward rushes and got in some good kicks, but did not find touch often enough.

The London outsides were good, especially Lloyd, Gibson, Oakely and Beale. They all tackled and kicked well, but their passing frequently broke down chiefly on account of the splendid tackling of our men. Beale was very cool, and gained a lot of ground with his kicks. It was through him that London scored. He caught a high kick from Morgan, and then dodged the latter, who had followed up. While running along the touch-line at half-way he ought to have been tackled by the forwards, none of whom tried except Pinching, who could not quite reach him. Louisson then missed him badly. When eventually hemmed in he passed to Scott. Iles then gave to Gibson, who scored under the posts. It was a good try, but we ought never to have allowed it.

Our outsides kicked across the London goal line at least eight times in the first half. This was a great mistake, because if they had passed properly then we should certainly have scored, and so in all probability have won the match.

On the whole, London deserved to win on the day, but our men certainly were not up to form, except the forwards and Harrison.

Association Football.

Guy's v. St. Mary's.

Semi-Final Round.

This match was played at Acton. Mary's won the toss, and Guy's had to face the sun. Play at once settled down in the Mary's half, and about ten minutes from the start Barber scored the first goal from a shot of Lichfield's, which hit the post. At half-time Guy's led 4—0.

In the second half the Mary's defence proved absolutely incapable of checking our forwards, and the only two occasions on which their attack promised to beat our defence, Collins refused to surrender. Result.—Guy's, 12; Mary's, 0. The goals were scored by Barber (9), Lichfield, Piper and Berry.

Remarks.—Barber was quite unable to miss the goal. All the forwards and halves were very good, and unusually quick on the ball. The defence was only troubled on two occasions, on both of which it acquitted itself with great distinction.

(Owing to pressure on our space, the account of the Inter-Hospital Assault-at-Arms is held over until our next issue.)

Reviews.

Guy's Hospital Reports. Vol. LVIII. London: A. & J. Churchill.

Two-thirds of this volume are occupied by a solid piece of work by Sir Cooper Perry and Dr. Shaw, consisting of abstracts of all the cases of gastric carcinoma in the post-mortem room from 1826 to 1900, with a well-prepared index. Preceding the list of cases are some observations by the authors, among which we note for mark those on hæmorrhage as a cause of death in gastric growth, on general peritonitis and its failure to be diagnosed before death, and the occurrence of dysphagia with growth of the cardiac orifice, as being fresh and not generally known.

Dr. Hale White writes on "Diseases of the Heart due to over-indulgence in Alcoholic Drink." We are surprised to find, on looking up the literature, how little has been written on this subject in England, and hence are pleased to see Dr. Hale White making a definite start to draw the medical profession's attention to the occurrence of the disease.

Dr. C. A. Ensor contributes an extremely interesting addition to the literature of Angeio-Neurotic Œdema in the form of a family history. As not being generally known, we note the high percentage of deaths from suffocation in this family, actually 12 out of 33 cases, and also that males, in this family at any rate, are twice as frequently affected as females. A more interesting little paper it would be difficult to find.

Dr. French, on "Eosinophilia in Skin Diseases," recommends blood counts in most skin affections as very (and occasionally extremely) interesting. His conclusions are that a few conditions, in which only one case was examined, showed eosinophilia, in many diseases there is no eosinophilia, and in others it appears to be a matter of chance whether they have it or not. Dr. French informs us that he took two hours to examine each slide, and he has examined 90 slides.

Dr. Fortescue Brickdale's thesis on the "History of Intravenous Injection of Drugs, with Experiments on Animals," is thoroughly well worth reading. The historical portion, tracing how the reasons or mode of injection varied with the altered ideas and knowledge of pathology is indeed interesting.

In the second portion of the paper is given the result of personal experiments of intravenous injection with antiseptics, from which he arrives at the following, almost-to-be-foreseen conclusions. That antiseptics have a toxic action, that animals die sooner when treated thus, and that no toleration of the drug is produced. We admit to feeling a little depressed, when it is forced on us, what little advance has been made in this direction during the last 250 years.

Death.

WALLACE.—On the 1st March, at Foulden Lodge, Upper Clapton, Annie Watson, wife of Frederick Wallace, L.R.C.P., Lond., and daughter of the late Thomas Warr, Esq., Manor House, Mare-street, Hackney, and Velmead House, Hants.

Ed.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 415.] MARCH 26, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	121–123
Smoking Concert	123
Lobar Pneumonia and Broncho-pneumonia. Clinical lecture by Dr. Hale White ...	124–130
Case of Henoch's Purpura	130–131
Cancer in Kafirs: Suggested Cause... ...	131–133
Notes from Skin Outers	133
In Lighter Vein	134–135
Correspondence	135–136
Pupils' Physical Society	136
Specialities	136
Case of Recurrent Attacks of Jaundice. Operation. Removal of Gall-stones. Cholangitis. Recovery	137–138
Dental News...	138
Reviews	138
Pass List	138
Sport	139–140

Passim.

SIR SAMUEL WILKS continues in much the same condition. He takes his food fairly well and seems to enjoy it, and sleeps without any sedative. He for a moment recognises Mr. Porter Wornum, and then seems to forget. Dr. Pye-Smith did not see much change in Sir Samuel, except that every day that passes without a definite return to intelligence, makes the outlook more grave. There is no pain, and his answers are always cheerful.

WE have received the following note from Mr. Symonds with regard to Sir Samuel's condition; he says, "I have just seen Sir Samuel Wilks. He was sitting up in bed drinking coffee, and recognising me, made many amusing comments, though relapsing very quickly into incoherence. This morning he sat up in bed and ate a poached egg and toast, cutting it up himself. He looks better. . . . ."

BY the death of His Royal Highness the Duke of Cambridge, the Hospital has lost one of its oldest Governors. Elected on to the Board in 1859, he manifested considerable interest in the work of this institution, and visited the Hospital on several occasions, the last time being in May, 1897, when His Majesty The King, then Prince of Wales, opened the new Physiological Buildings. In connection with his interest in a less official capacity in Guy's and its welfare, rather an amusing incident occurred at a performance of the Disguysed Minstrels at St. George's Hall. A popular member of the troupe was engaged in singing a topical song which contained innocuous though scarcely respectful reference to the Royal Family, both individually and collectively. In the full fervour of his song, before the fatal verse, the singer caught sight of the well-known form of the Duke of Cambridge in the front row of the stalls. For a moment he hesitated, terror seized him, and a cold sweat breaking out damped the usual conviction of his performance. Then, being destitute of "gag," and with the courage of despair, he decided to risk it, with the result that the Duke laughed as heartily as anyone, to the relief of more than one anxious minstrel who had foreseen possible rocks ahead.

WE take this opportunity of calling the attention of qualified members of the Dental Society who have left the Hospital that at a meeting of the Society held on February 19th, it was proposed and unanimously agreed to—"That as Mr. J. H. Badcock has resigned his position on the Dental Staff of this Hospital, some recognition of the fact should be made by this Society, with which he has been associated since its formation in 1894." A sub-committee was appointed to carry this proposal into effect, and subscriptions may be forwarded to Mr. Prideaux, at the Dental Department, not later than March 31st.

The Smoking Concert of March 12th was an unqualified success, and the united efforts of a small but zealous band of organisers were rewarded by an enthusiastic house and a good programme. The variety part of the performance gained immensely by the erection of a stage of considerable dimensions, which, with the curtain, lent an additional air of importance to each separate turn. A motor car was manœuvred with perfect ease and safety, and tight-rope and other acrobatic feats of extreme difficulty were performed, both of which would have been impracticable upon the time-honoured diminutive platform. As regards the play, the main object was most certainly achieved, namely, general merriment, though there is room for doubt as to which enjoyed themselves most, the actors or the audience. It is perhaps a matter for regret that the æsthetic worth of the dialogue should have been eclipsed by the remarkable spontaneity of the leading performers, which, in many places not only robbed the audience of passages of remarkable beauty, but went far towards creating a fundamentally wrong conception of the plot. This latter point may perhaps have been a blessing in disguise, for the tone of the play was the reverse of healthy, and certain situations in the original text were distinctly impolite. The Warden generously suffered his sanctuary to be broken in upon, and the easy communication thus effected between the College corridor and the stage was a great boon to the performers. Many thanks are also due to Mr. Barnes for the fitting up of the footlights, and to the Works Department for the erection of the stage and sundry ambitious properties.

For some time after the appearance in our columns of a certain article on "The Sister" we had lived in fear of our lives. Love of truth had forbidden the suppression of the article, but it is only to the somewhat Spartan philosopher that that virtue can supply the necessary boldness in the face of wrathful indignation. Days, nay weeks passed, and we were beginning to lift our heads once more, thinking that possibly fate intended after all to deal kindly with us in delivering us out of the hands of our enemies. But now, and at last, the blow has fallen and vengeance has overtaken this unhappy journal in a sudden and terrible form. A more complete and awful revenge it would be impossible to devise. The aforesaid article has been *misquoted*, and *in the Daily Mail!* One miserable sentence, meaningless by itself, was torn from its context and headed wrongly. "Lofty superiority of a nurse" has been presented to the greedy consumers of half-penny wisdom. Where now is the glory of publishing the truth—truth which was so instantly recognised by the medical world that two hospital journals and a nursing paper demanded permission to reprint it and thousands of meek nurses shouted for joy! Truly our punishment is greater than we can bear!

The Annual Meeting of the Students' Club, which was held on Thursday afternoon last, was much better attended than has been the rule of late at these meetings, and the increased efforts of the committee in this direction were rewarded by some show of interest on the part of the men. That the greater number of those who took the trouble to be present and to assist in the choice of student representatives should have been men who are living or who have lived in the College, is perhaps natural, but it is a pity that more of the junior men did not attend, for it is after all they who will be most affected by the legislation of the committee. The old question of the catering was dealt with once more, and although it was promised that the proposed innovations should receive the "respectful attention" of the authorities, yet the outlook would seem to be sufficiently hopeless.

The board over the mantelpiece in the Smoking Room, which is intended to immortalize the generous donors to the Students' Club also came in for its fair share of abuse. It was rightly agreed that acknowledgment of some sort should be made of the various benefits named thereupon, and in spite of the fact that there was strong feeling that the acknowledgment might be made in a less banal manner, the majority of those present at the meeting could find no better way of expressing gratitude than by some similar, if more ornamental tablet. Pro-

bably the result of the controversy, will be a beautiful piece of carved and polished wood, a concession to the artistic, which shall be hidden away in a dark corner of the room as a concession to the sensitive. In short, an unsatisfactory compromise, which will please nobody and aggravate not a few. In the meantime, however, any suggestions that may occur to individual members can find a vent in our columns, and will be welcomed by the committee.

Another point not mentioned at the meeting is the desirability of reviving a custom which held good and was most useful only a very few years ago, namely, the practice of announcing in some way or another the arrival in the Hospital of each individual member of the Staff. The present state of affairs is most unsatisfactory, more particularly in the winter months. It is true that a few—a very few—of the Staff are as punctual as clockwork, and the dresser or ward clerk knows the exact time when it will be necessary for him to be in the Colonnade; but it is also true that the time of some arrivals is blissfully uncertain, and many precious half-hours that might be spent warmly and profitably in the Smoking Room are wasted in a cold Colonnade. This can he easily obviated, seeing that the College and the Porter's Lodge in the front entrance are connected by a species of telephone, and it only needs a word from the committee to effect an innovation that will call down blessings on their heads.

It seems a suitable time to remind men of the existence of the Swimming Club which has not been patronized much during the last few years. Now that we have a swimming bath on the premises, it is difficult to see why this club should not be in a most flourishing condition, and it is to be hoped that the approaching summer session will see a revival at Guy's of what was once a most popular sport. In connection with this same topic, it is time another protest was made at the way a great many men treat the swimming bath. The rule is that boots should be removed in the ante-room to avoid the unnecessary admittance of dirt, which makes the floor at the side of the bath so objectionable for bathers. That many of those who use the bath ignore this rule is easy to see from the condition of the floor, and when the rule is one which can so easily be obeyed it is difficult to condemn too strongly so flagrant an exhibition of selfishness.

The following letter from the *Charing Cross Hospital Gazette*, will appeal to everyone who has in any way studied the working man within our own walls.

Dear Sir,

Ma I jest take a few lines of your valuable papper to pertest agin me & my mates bean hindered from urning our daily bred by peple gallyvarnting abt the scool wile were trine to wurk 4 instans its reely impossible to lay bricks proply with a bloke a lecshuring just abuv yer ed an then the libery its most distractin to ave peple warking abt an feching boox wile your trine to nale up a plank an as 4 a quite smoak an a snoos its impossibull wy carnt they leve the lekshers & reding & things till weave finished

Yors disgusted
BILL SMITH
(Assistant Bricklare)

It is a matter for thankfulness that all our laurels have not been snatched from us, and that though we have lost the more popular trophy in the Rugby Challenge Cup, the Association eleven have been able to defend their Cup against attack. The Hockey team also have added an ornament to the Smoking Room, and it is to be hoped that this season has firmly established their fortunes and given them a reputation which they will keep for many years to come.

Smoking Concert.

The Second Smoker of the Session, which took place in the Dining Hall, on Saturday, March 12th, was one of the most successful that has ever been held, the room being crowded to overflowing. There is no more popular chairman on these occasions than Mr Dunn, and his entrance was the signal for a loud burst of cheering, after which the proceedings commenced with a pianoforte solo by Mr. Ticehurst. Mr. Parrot next sang "The Mediæval Knight," after which Mr. Ray Edridge gave a recitation from Rudyard Kipling in characteristic style. Comic songs were contributed by Mr. E. H. Crawley and Mr. B. H. Palmer, and a capital musical sketch by Mr. C. E. M. Jones and Mr. H. M. Woodward entitled "The East End and the West" was immensely appreciated. Mr. J. E. Collins was equally successful in his Tramp Sketch, which fairly brought down the house. Mr. Sidney Bowle, in the place of Mr. Wyatt, sang a song from the "Gondoliers," and this brought the first part of the programme to a close, after which was presented a new and original play, an account of which appears on page 134. A dramatic sketch at a smoker is an entirely new departure, and the Re-idents are to be congratulated on an original idea which proved to be a singular attraction and contributed in no small measure to the enjoyment of the evening.

Lobar Pneumonia and Broncho-pneumonia.

CLINICAL LECTURE BY DR. HALE WHITE.

November 7th, 1903.

GENTLEMEN,—You will remember that at the last lecture I told you about some cases of Lobar Pneumonia that were in John and Miriam wards, and I mentioned the man in No. 4 bed, whose condition we thought grave, solely because his pulse was so rapid and weak. He had a leucocytosis of 50,000. Our fears were justified, for he died about thirty hours after the lecture. So he teaches what I tried to urge, namely, the great value from the point of view of prognosis, that you should place upon the pulse, and he seems to show that a bad prognosis derived from the pulse is not outweighed by a good prognosis from a high leucocytosis. Another case I referred to last time was that of a man in whom the outlook appeared very serious, because his temperature was not high. It often reached 100°, but rarely reached 101°, and sometimes it was as low as 99°, although he had extensive double pneumonia. He died last night. So in the week between the last lecture and to-day two fatal cases have illustrated some of the points which I mentioned to you as bearing on prognosis.

I have a few more words to say about lobar pneumonia before we pass on to broncho-pneumonia. We had, for want of time, on the last occasion, to omit all mention of the complications of lobar pneumonia. I think that among hospital patients the most striking and serious complication that you see is delirium tremens, and certainly it is of very grave omen. It is exceptional for a hospital patient to get well in whom delirium tremens complicates pneumonia. The practical point in connection with this is, that not infrequently the patient is seen to have delirium tremens, and those who see him are inclined to regard that as his only illness; they omit to examine the lungs, and therefore they fail to discover the pneumonia which has been the contributory cause of the delirium tremens. That delirium tremens itself is a disease of which the outlook is grave, is well known. There is the classical instance of the death of Falstaff, and you remember Mistress Quickly knew the seriousness of delirium tremens, for she said, "For after I saw him fumble with the sheets, and play with flowers, and smile upon his fingers' ends, I knew there was but one way; for his nose was as sharp as a pen and 'a babbled of green fields." Those symptoms now, as then, indicate a fatal end. As we have recently had a case in John ward of delirium tremens complicating pneumonia, I might briefly tell you about the treatment of it. The great thing is to get the patient to take food, and I believe that when delirium tremens is present more than in any other case of pneumonia, you should push digitalis fully and also try to get the patient to sleep. Lately I have been giving paraldehyde. Only this morning I heard of a patient for whom I had given paraldehyde in delirium tremens, that it had succeeded better than anything else. If that fails you may try hyoscine. It is very important, by one of these means to get the patient to sleep; sleep, food and digitalis are the great things. You will remember, in Sir Samuel Wilks' lecture on delirium tremens, he truly urged that you can frequently get these patients to sleep if you keep them quiet. It is no uncommon thing among the poor to see a man with delirium tremens who has half a dozen men and women round him trying to "cheer him up." Those are about the worst surroundings possible for such a patient.

The next most frequent complication we see here is probably empyema. It occurs in 4 per cent. of all cases of lobar pneumonia. You most easily recognise it when there is an apyrexial interval of a couple of days after the crisis, followed by a rise of temperature, and when the crisis is followed by a drop in the leucocytosis followed by a rise, these symptoms together are certainly indicative of empyema. But there is sometimes much difficulty, for the pus forms so coincidently with the pneumonia that there is no apyrexial interval, and there is no serious drop in the leucocytosis corresponding with the crisis. If you think of it, the subject clearly wants elucidating, for when the pus is present in the chest after pneumonia the usual temperature which you see with the pus is one with wide daily fluctuations. In pneumonia the temperature keeps fairly level, often varying only a degree in a day. So it appears that when the pneumococcus affects the lung it produces one type of temperature, but when it causes empyema — for these empyemata are nearly always pure cultivations of the pneumococcus— the temperature conforms to a different type. It is difficult to see why that should be, and also why as the pneumococcus causes both the pneumonia and the empyema, there should be an apyrexial interval. Next you will look out for the the physical signs of empyema. I am

accustomed to attach great importance to local tenderness as indicating pus, and the physical signs are often the most difficult of any in medicine to interpret, because you may have to try to discover a small empyema when there is extensive consolidation of the lung, and much pleurisy all round. Therefore you cannot have too many helps, and I have more than once been guided accurately where to put the exploring needle by the local tenderness.

The next complication is pericarditis, and it is curious that it is not more common. In the case of the man who was in No. 4 bed, and who died, we were rather surprised to find that he had no pericarditis as he had so much pleurisy on the outside of the pericardium. Even when the empyema lies in contact with the pericardium there is often no pericarditis. Another peculiarity is that pericarditis rarely forms pus, although empyema is not rare. To give you a notion of the rarity of pus in the pericardium, we do not average more than one case in two or three years in the whole hospital.

The other complications I will very quickly run over, for they have not been exemplified by the cases we have had in the wards. One is malignant endocarditis. The pneumococcus may become grafted on to the valves, and we had a sad case some years ago in a student in whom that happened. Emboli were carried from the fungating endocarditis, the hepatic arteries became plugged, there was an aneurysm of each branch of the hepatic artery, one of these pressed upon the bile duct, and gave him jaundice, and one morning one of the aneurysms suddenly ruptured, and he died in a few minutes. The pneumococcus may give rise to sore throat; meningitis may follow from an invasion of the meninges by the pneumococcus, and that is of great clinical importance, for it is often extremely difficult to separate the delirium due to the pneumonia from the mental symptoms due to an actual meningitis. Over and over again one sees cases in which it has been quite impossible to say for certain whether the delirium was due to meningitis or merely the delirium of the pneumonia. You will remember that occasionally arthritis occurs in the disease, the effusion into the joint being due to the pneumococcus. And occasionally abscesses occur in other parts of the body. I remember a gluteal abscess which gave a pure cultivation of pneumococci. Never forget that peritonitis may be caused by the pneumococcus, for this may be important clinically. And last time I showed you two specimens of colitis due to the pneumococcus, and I have seen a case this week. Ear trouble may be due to it, which is not surprising when we think of its easy connection between the throat and ear.

The last point in the matter of complications is, that students are often puzzled very much by the fact that the physical signs persist so long after the crisis. There is a case in Isolation ward where the signs had virtually gone a few hours after the crisis. But in other cases the physical signs remain so long that the patient leaves the hospital with the signs very little better than they were when he had a high temperature, and before the crisis. I think the explanation is this: that probably it depends on the amount of pleurisy. In a fatal case of pneumonia which we had in the early part of the six weeks I have been taking Clinical, the lymph we stripped off the pleura was over an inch thick. That must take a long while to become organised, and it is doubtful whether in some cases the physical signs would disappear in many months. At any rate I am certain that ordinary lobar pneumonia rarely, if ever, probably never, passes on to fibrosis of the lung. Our museum contains no specimen in support of that. When anyone maintains to you that a chronic lung disease can follow an attack of acute lobar pneumonia, you will find he has got no post-mortems to prove his point; he has probably been misled by the thickened pleura which may remain.

We naturally pass from the consideration of lobar pneumonia to that of *broncho-pneumonia*. We have plenty of cases to illustrate it. The importance of this disease of the lungs, which is so closely allied to lobar pneumonia, is very great. I copied down the mortality of the New York Infant Asylum, and I find that among 726 consecutive post-mortems, in 322 the death was due to broncho-pneumonia. The next most frequent cause of death was gastro-intestinal trouble 189, tubercle 56, and marasmus 26. Other causes of death were comparatively infrequent. Broncho-pneumonia is almost confined to infants. For example, half the cases in the New York Infant Asylum were under one year, and considerably more than three-fourths under two years. After five years of age it is exceptional to meet with this disease. Remember that our experience of it in the hospital is very gloomy. You see much of it here, but when you get into private practice you will see comparatively little, for it is very frequently associated with bad feeding and bad hygiene; this is partly because broncho-pneumonia is frequently secondary to measles, scarlet fever, and whooping cough, and the poor have not the opportunity of successfully combating these

diseases of childhood, whereas well-to-do children usually recover from them without complications. Apart from that, too, broncho-pneumonia is indirectly dependent upon bad feeding.

The very name tells you what is essential about the disease. It is broncho-pneumonia; the process begins in the bronchi and from them spreads laterally to the lung, and along to the alveoli. The result is that—as in the lungs taken from a child who died yesterday, and which I now show you—the process spreading from various points in the bronchi, numbers of small areas of inflammation are dotted about the lung, and you are not surprised to hear that frequently these do not clear up, indeed they may sometimes pass on to chronic fibrosis. In lobar pneumonia the condition is different, for there is frequently comparatively little coincident bronchitis. In lobar pneumonia a large amount of fibrin is poured out into the air cells, much as you might fill them with tallow, and a large area becomes involved at once, but there is comparatively little affection of the tubes and lung tissue, and the exudation quickly clears up. But there is a good deal of bronchitis in broncho-pneumonia; when you squeeze the lungs you get pus from the tubes, as you see I can now; and as you would expect the inflammatory products to gravitate to the back of the lungs with the patient lying in bed, the disease is far more common at the back and base of the lungs, a point also shown in the specimen before you. In children, if you cut a section of the broncho-pneumonic lung, you can see the inflammation spreading from the bronchi into the surrounding lung tissue, and if your section happens to be parallel with the bronchus you can trace the inflammation along the bronchus. The scattered patches of inflammation about the lung very often look like minute areas of lobar pneumonia, and sometimes, as I will tell you in a moment, they are of the same nature as the diseased lung of lobar pneumonia, only they are very small and scattered about. Often, too, they are grey, and you know that frequently it becomes difficult to distinguish them from tubercles. If the process is acute there may be, as we have frequently seen in the post-mortem room, hæmorrhage into the lungs. Another further result is that the secretion resulting from the bronchitis plugs the tubes, and when that happens the air in the air cells is absorbed and the lung collapses, and you will remember the collapsed areas associated with broncho-pneumonia which have been pointed out to you in the post-mortem room and which I show you now.

In children, emphysema, both alveolar and interstitial, rapidly occurs after broncho-pneumonia. It is, as you see, beautifully shown in the specimen from yesterday's case. The whole of the front of both lungs is emphysematous, while at the back there is typical broncho-pneumonia. Frequently the bronchial glands are enlarged, and that is so here; and there is often some pleurisy over the inflamed lung. And you will not be surprised that tuberculosis not uncommonly follows in such a lung as this.

In many of the cases no other micro-organism than the pneumococcus is found. But in more than half there is a mixed infection. Probably the cases in which you see small areas of lobar pneumonia scattered about are due solely to the pneumococcus, and, if carefully examined, every such case would show fibrin to be exuded, as in ordinary lobar pneumonia. But even if the case is due purely to the pneumococcus, and the patient is under two years, for some reason we do not at present understand, the distribution is lobular. I confess that none of the so-called explanations of that are, to my mind, clear. But I think there can be no doubt that this striking difference between the broncho-pneumonia of children and the lobar pneumonia of adults depends upon some difference between the lungs of a child and an adult, and not upon a difference in the infection. But remember that in these cases of broncho-pneumonia, whether solely due to the pneumococcus or to a mixed infection, there is always a good deal of bronchitis present.

I thought I would next take an individual case for discussion of the symptoms of broncho-pneumonia. Here are the notes of a very severe case, probably due to a mixed infection, in a child four months old, who was admitted this week, on November 2nd. Mr. Goss reports that for some days before it became seriously ill the child had a cough. That is interesting; it is different from the lobar pneumonia of the adult, in which the onset would have been sudden. As a rule, broncho-pneumonia is of gradual onset. The child got worse, and on the morning when the mother brought it in the breathing was very bad. The motions were very green, showing that there was gastro-intestinal disturbance, which frequently occurs in these children; and the importance of that in prognosis is very great. The mother said the child had been convulsed, and that is of much importance for it considerably increases the likelihood of death. When admitted, the child was cyanosed (another bad sign); the pulse was 190, the respirations 80,

and the temperature 105°. So it was a very severe case. It was noticed that the lower four or five spaces were sucked in on each side, and that was because there was some collapse present as well as pneumonia. On examination it was found that there was some impairment of note at the right base, and on auscultation numerous râles could be heard all over the chest, less marked at the right base, and most at the left base. On the right side there were several small areas of bronchial breathing. That is the usual physical state of the chest in severe cases. First I would say it exemplifies what I said about the process being mostly at the base and the back. Next, as you would expect, there is not much dulness, for dulness can only be produced in broncho-pneumonia by a number of small affected areas being so close to one another that they make one large area. And that will usually only occur at the bases. Still, when the case is very severe, adjacent consolidated areas are close enough together to enable you to obtain a dull note; they give you bronchial breathing, and the fine bright râles characteristic of solid lung. Our case showed all these points. I will now show you the temperature chart. You see the temperature fell a little after admission, but it subsequently rose to 106°, and that being usually of fatal augury, we were not surprised when the child died soon afterwards. I think it is necessary to point out to you that in a very bad case the child may die before there are any physical signs.

I mentioned that in this child the onset was gradual, and that is usual; but in the cases which are purely pneumococcal the onset is very often, perhaps always, sudden. That was well illustrated in a child in Isolation ward, named Florence Clements. She came on the 4th of this month, and we found she had a sudden onset of illness at 1 a.m. on that day; and on going over the case we found that there were large areas of consolidation, and the case tended rather to the lobar type; it is probably a pure case of the pneumococcal form, and not a mixed infection. That was also borne out by the way in which the temperature came down quickly. Mr. Goss looked up the old reports, and found that Florence Clements was admitted under Dr. Taylor in 1902 for broncho-pneumonia at the right base. Look at this chart and see how quickly the temperature fell; it was then probably a pure pneumococcal and not a mixed infection. Later on in 1902 she had a second attack of broncho-pneumonia at the left base, of which I show you the temperature chart, and that again terminated by crisis. So, although the child is alive, and we therefore have not proof, I think the case may almost certainly be taken to illustrate admirably that when broncho-pneumonia in little children is due solely to the pneumococcus, the disease tends to present the clinical type of lobar pneumonia in the adult. The attack for which the child is now in the hospital ended on the ninth day, has ended by crisis, like lobar pneumonia in the adult.

Inasmuch as mixed infection cases are commoner than those of pure infection you are not surprised to learn that the disease usually ends by lysis, and the temperature is, generally speaking, low in the weak, underfed and debilitated children we get here. Of course, with lung disease in a child, the respiration is particularly rapid; in the case I read to you the rate was eighty. The pulse is rapid and cyanosis is not uncommon. You must not expect to find any expectoration, for it is usually coughed up as far as the throat and then swallowed. When you consider how painful lobar pneumonia is in adults, it is curious that children with broncho-pneumonia rarely complain of pain. I have referred to convulsions and delirium, and these children not infrequently get gastro-intestinal disturbance. Usually the pyrexia is more prolonged than in ordinary lobar pneumonia; it generally lasts between ten and twenty days.

I will recapitulate the physical signs of broncho-pneumonia. You will get many more signs of bronchitis than of pneumonia, because the pneumonic areas are so small. Usually for some days there will be nothing but signs of bronchitis; and then on going over the chest you will notice the râles that are beginning to get bright and suggestive of solid lung here and there, and you can hear imperfect bronchial breathing, especially at the back of the lung and towards the base. Then if the case does not clear up, and the patient lives long enough, small dull areas will appear. Those points were illustrated by the first case I read to you. It is not uncommon for the child to be severely ill for a week or ten days before you get any physical signs indicating consolidation. I have tried to impress upon you that most of the cases are secondary to some other disease, especially influenza, measles, whooping cough, or diphtheria; and it is frequently secondary to what we call marasmus, which is hardly a disease, for it means imperfect feeding. It is also met in various gastro-intestinal disturbances.

Next as to prognosis. You have to bear in mind that broncho-pneumonia is a very serious disease. In most institutions the mortality is 60 per cent. or over. One of the most important

factors in the prognosis is the age; the younger the child the worse the prognosis. The little child in Miriam who died this week was not badly nourished; it had always been brought up by the breast, and one did not see why the child should succumb so rapidly, except that the age was only four months. Of even greater importance is the general condition of the patient. You all know the weak, miserable, thin-skinned infants, that have lost weight often since their birth, who are brought up here, and we say they are suffering from marasmus, whereas they are really suffering from ignorance or wilful neglect on the part of their mothers, because marasmus only means the starved condition that children who are improperly fed and clothed get into. And you know such children when admitted here with broncho-pneumonia nearly always die. Another point of importance in prognosis is whether the disease is primary or secondary. As far as we can make out, in the child Clements it was primary, and she has got well, although she has had three attacks. If it is secondary, the prognosis is much worse, and, unfortunately, most of the cases are secondary to some other disease. What it is secondary to will naturally bear upon the prognosis, for instance, a case which is secondary to measles usually does not do so well as one secondary to whooping cough. On the other hand, one secondary to scarlet fever is in a very serious way, as also is one secondary to diphtheria. Rickety children do badly, as you would expect from the shape of the chest. I told you a very high temperature was bad in lobar pneumonia, and the same is true of broncho-pneumonia. Our fatal case had a temperature of 106°. But I also mentioned that if in lobar pneumonia the temperature was not so high as to be in itself a danger, a high temperature was—other things being equal—desirable; the same is true of broncho-pneumonia. In the New York Infant Asylum, Holt tells us, that in a number of cases of broncho-pneumonia, when the temperature was 106° or over, the percentage of deaths was 85·5.; when between 105° and 106° it was 60 per cent, between 104° and 105° 49 per cent., between 102° and 104° 60 per cent., so that with the lower temperature the mortality begins to mount again. When the temperature never exceeded 102° the mortality was 71 per cent. Children with broncho-pneumonia who are cyanosed I think always do badly. The child in Miriam was cyanosed and it died. I have sometimes bled them when they were cyanosed, but I have not often succeeded in saving them by so doing. If the physical signs are very extensive the child will, other things being equal, do worse than a child with less extensive signs; but in primary cases, as in lobar pneumonia, the general toxæmic condition is more important than the physical signs. The next point is very necessary to remember, and that is the state of the digestion. You know how many of these children who come with broncho-pneumonia have gastro-intestinal trouble. They have vomiting and diarrhœa, and if you cannot check that, they will almost inevitably die. Our fatal case illustrates the last point with regard to prognosis, and that is, when they have delirium and convulsions they do badly, especially if the convulsions occur towards the end of the illness.

The next matter is what to do for them. I have said the disease is most often seen among the poor and underfed children, and those who are brought up in bad surroundings; and that gives you the key to the treatment. The diet should be so chosen that the child is not sick, that it has no diarrhœa; you will make no headway until you have stopped the vomiting and diarrhœa. The child should be in a light airy room with the windows open; and it should be kept well clothed and clean. And it is more likely to do well in hospital than if it remained in its own poor home. Do not keep these patients too long on their backs; that follows from what I have said about the disease being found chiefly at the back and base of the lungs from the secretions gravitating there. Turn them on their faces occasionally, and keep them warm by putting cotton-wool jackets on them. Can you get away the material which is blocking up their lungs? I think the best way of doing that is by an emetic; and unless the child is so collapsed—as they often are—that the depression of an emetic will probably kill it, you will do most good by giving a drachm or two of syrup of ipecacuanha. It is quite striking how this will often clear the lungs. What I said about expectorants in regard to lobar pneumonia holds good here also. The child will not make progress unless it takes its food properly; and if you give it nauseating expectorants, such as senega, squills, carbonate of ammonia, and so on, you cannot expect it to enjoy its food. I believe terebene is one of the best expectorants. Strychnine is most important. It stimulates the respiratory centre and keeps the heart going. The strychnine can conveniently be given subcutaneously; but you should never give a child under one year more than the $\frac{1}{200}$ of a grain at a time; but you may repeat it frequently, and

watch the child. Alcohol is very good treatment too, because it stimulates the heart, and it is a food, but I do not think a child of one year should ever be taking more than six drachms of brandy in twenty-four hours, and that is a large dose. Digitalis may be useful, as we saw it was for lobar pneumonia, but the objection is that it often makes the patient sick. Oxygen certainly seems to do good, especially when there is cyanosis, as we saw it did for lobar pneumonia. Above everything, do not give antipyretics, and what I have said about pneumonia applies even more forcibly here, because phenacetin, antipyrine, and antifebrine cause serious collapse and may kill the child. Many people attach much importance to inhalations, and you may see a bronchitis-kettle going in the room. I do not attach much importance to them myself, because with the kettle going the windows are generally closed, and it is better to have fresh air. Again, if you saturate the air of a room and the temperature falls, moisture is precipitated, and it gets on the child and its clothes and cools it, and that is bad. Sometimes when these children come in they are so collapsed that you want to do something to bring them round at once; and then you cannot do better than we did in our fatal case, that is, give the child a hot bath with some mustard in it. If they are very collapsed you must transfuse them.

Let us now take diagnosis. A practical point which often turns up, and is bothering us in Isolation ward, is, Has the child got tuberculosis or broncho-pneumonia? I am sorry to say that in many cases you cannot settle the question, nor can you expect to settle it, because generally in children tubercle of the lungs produces no other physical signs than those of the broncho-pneumonia set up by the tubercle bacilli. I can only make some obvious remarks to you as to what should guide you The most direct guide is, whether you can find tubercle elsewhere in the body. For instance, look at the glands in the neck, for such information will be a valuable guide. Unfortunately, it is very difficult sometimes to get the expectoration of children to examine; but if you pass the stomach tube a little way down the œsophagus and then examine the stuff that sticks to the outside of it, you may sometimes find tubercle bacilli in that, and that will settle the diagnosis. If the child is profoundly anæmic and much wasted, that is in favor of tubercle, also if the disease has come on very slowly. If the trouble is chiefly basal it is in favor of broncho-pneumonia; if it is chiefly apical it is in favour of tubercle. I have jotted down some points which will help you in telling whether a case is broncho-pneumonia or lobar pneumonia. It is of very considerable importance, because if it is broncho-pneumonia it is the category of diseases with a mortality of over sixty per cent., whereas if it is lobar pneumonia, that disease in children has a mortality of about six per cent. We have had some very good cases bearing upon that. More than half the cases of broncho-pneumonia are secondary to some other disease or to ill-feeding; lobar pneumonias are not usually secondary to anything. That is illustrated by a child in a cot in Miriam; and several cases we have had here during the past month have shown that. The next point is the age. About eighty per cent. of the broncho-pneumonias are under the age of two, whereas lobar pneumonias are rare under two. A child in Miriam with lobar pneumonia is about four years of age. The child who died of broncho-pneumonia was only four months old. A child which had lobar pneumonia at its apex was a little over two. Broncho-pneumonia generally attacks weakly and debilitated children, especially if it is secondary; but lobar pneumonia shows no such preference. The child with lobar pneumonia in the cot in Miriam looks a fine and healthy one. The child we had in the Whooping Cough ward which had lobar pneumonia was also well developed. Broncho-pnemonia comes on gradually, as a rule, unless it is primary; but, on the other hand, lobar pneumonia generally has a sudden onset. It is very necessary to remember that there is no typical course with broncho-pneumonia; you know you have a long lasting irregular pyrexia, with wide fluctuations, running on, it may be, for three or even six weeks and terminating by lysis. On the other hand, lobar pneumonias have a definite course, and the disease is soon at an end, as you see by the chart of the boy four years old. As you would expect, broncho-pneumonia is a disease of both lungs, affecting their bases and back parts, from the sucking in of the secretion from the bronchitis. Lobar pneumonia usually attacks one lung only, and that has been shown by our cases in the past month. I have tried to emphasize that with broncho-pneumonias there are little scattered areas of disease, while in lobar pneumonia the areas are fewer and larger. Broncho-pneumonia gets well slowly, often taking weeks for the temperature to come down. It is surprising how quickly lobar pneumonias clear up in children, and that has been admirably shown in several children during

the past month. Once a child gets broncho-pneumonia it frequently relapses and gets bad again, whereas the lobar pneumonias get quite well. Lobar pneumonia in children is hardly ever followed by complications except pericarditis and empyæmia. On the other hand, chronic pneumonia and tubercle are frequent after broncho-pneumonia Lobar pneumonia is always a pure infection, but broncho-pneumonia is due commonly to more than one micro-organism, though the pneumococcus is the most common.

Lastly, I have particularly tried to make it clear to you, by contrasting the case of the child aged 4 months, who was admitted on November 2nd, and whom we believe to have suffered from broncho-pneumonia, due to a mixed infection, with the case of Florence Clements, admitted November 4th, and whom we believe to have suffered from broncho-pneumonia, due to a pure infection of pneumococci, that probably there are two varieties of broncho-pneumonia, one due to a mixed infection, and one due to a pure infection with pneumococci, and that the symptoms of the two varieties are sufficiently distinct for us to separate them during life. It is probable, too, that the broncho-pneumonia due to a pure infection of pneumococci resembles lobar pneumonia in being usually primary, while that due to a mixed infection is usually secondary, and has a much higher mortality.

Case of Henoch's Purpura.

I READ with much interest Dr. Hale White's lecture in the GAZETTE on Henoch's Purpura, and think it may interest some of your readers if I give some notes of a case of the disease which occurred in my practice last year.

G. C., a girl æt. 12½, first seen by me August 22nd. Previous history. — Mother said that she had had "dysentery" at the Cape at the age of three. Nothing serious since. No evidence of hæmorrhagic or rheumatic diathesis. Seven days before I was called in she had a sore throat, which got well in a day or two: the doctor in attendance only saw her twice. When I first saw the child I found her of clear complexion, healthy looking, well nourished, but a little anæmic. Over the lower extremities was a vivid hæmorrhagic rash. The spots were dark red and slightly raised, petechial in character, from a quarter to half an inch in diameter, the smaller and duskier and apparently older ones being on the legs, and the larger and brighter on the thighs. Several large ones coalesced on the inside of the buttocks. The spots had all come out within twenty-four hours. Temperature and pulse normal. Tongue furred, bowels confined. No sickness, no abdominal tenderness.

August 23rd. Eruption fading, leaving yellow stains but there is some fresh eruption over the thigh in papules and raised white plaques or wheals, several with hæmorrhage in the centre. Tongue furred.

24th. Child has pain in abdomen and has been sick several times. Some bright red blood, less than half-drachm altogether in the vomit. A few fresh papules and petechial spots.

25th. Child again sick several times, occasional bright streaks of blood in the vomit.

26th. Bowels acted several times. Some bright liquid blood in the motions, sickness continues. Patient looks really ill to-day for the first time. Tongue coated with white fur, yellow down the centre. Has been taking peptonised milk only. A few more raised spots symmetrically placed on back of elbows. Patient has been taking peptonised milk only, but is now to be fed on nutrient enemata. Breath most offensive. Vomit of bilious character.

27th. Patient has not been sick but has passed several motions liquid and mingled with fresh blood. Tongue still furred. She complains of "cramping" pains in stomach before the motions are passed, relieved by passing them. Temperature 97°, pulse 86. Urine, high specific gravity, otherwise normal.

28th. Patient has passed blood in the motions six times in twenty-four hours. The child, who is of an excitable disposition, is very prone to flushings of the face during this illness.

29th. Bowels moved several times with bright blood in small quantity, intimately mixed with the motion. Breath most offensive.

30th. Child much better. Not been sick. Bowels not acted, no abdominal pain. Tongue furred. Child bright and lively. Nutrient enemata omitted.

September 1st. Fresh spots yesterday afternoon, hæmorrhagic, one-sixteenth to one-eighth of an inch in diameter over legs, and larger over buttocks symmetrical.

4th and 6th. Fresh crops on legs and elbows.

8th. Child looks ill again. Very dark round the eyes. Has had several attacks of pain in the abdomen coming on paroxysmally. The pain is about two inches to left of umbilicus as it has been throughout the illness. The child has been sick several times to-day. There is a fresh crop of spots consisting of agminated pink papules with slight itching. The hæmorrhage in them cannot be expressed. Breath most offensive.

10th. For the last two days the abdominal pain has been continuous but mild in character. It is increased on pressure. There is a paroxysmal outburst at times and this is often produced by the food (peptonised milk and Benger's food, ʒi. every two hours).

13th. Child much better. Bright and hungry. Tongue clean, red, and pointed.

22nd. A few more spots or plaques have come up the last few days but not in any number. The tongue still

keeps clean, and the child can take fish diet without discomfort.

November 1st. The child has got gradually stronger and to her normal condition. There have been a few more spots but no internal hæmorrhage.

Remarks.—The skin eruption was variable, sometimes being purely petechial or erythematous with hæmorrhage into the spots, at other times the rash was largely urticarial with hæmorrhage much less marked.

The abdominal pain was severe and colicky, requiring small doses of morphia. The abdomen was a little full but always soft. Food made the patient sick and she could only keep down small quantities of peptonised milk and lime water, and for four days had to be kept on nutrient enemata only. The bowels were constipated at the beginning and throughout, except when there were attacks of abdominal pain, when diarrhœa was present. Adrenalin Chloride, gr. x. P. D. & Co. 4tis horis was given for the hæmorrhage, but with no effect. When the acute symptoms were over, the patient took Calcium Chloride, gr. vj. t.d.s. for three weeks, but I think the disease followed its natural course towards recovery, unaffected by medicine.

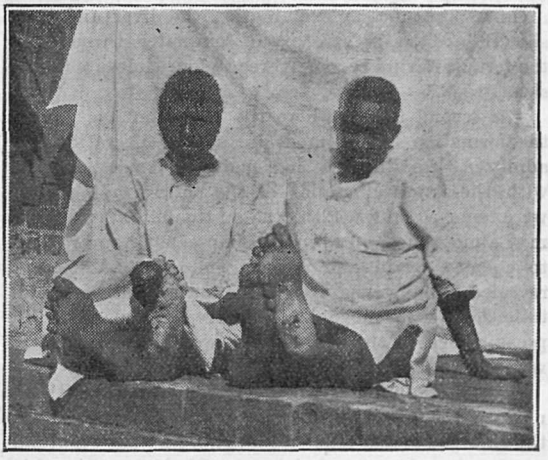
Pain in the limbs, but not in the joints, was a frequent symptom, a feeling of cramp occurring just before the eruption appeared. A noteworthy point in this disease which I think was not referred to by Dr. Hale White is that the abdominal symptoms may be so acute as to lead to the diagnosis of intussusception, and the patient may be operated on unnecessarily. In the British Journal of Children's Diseases for January, 1904, two cases are related, aged five and eleven, in which the symptoms, abdominal pain, vomiting becoming stercoraceous and passage of blood led to the diagnosis of intussusception, and laparotomy was performed and hæmorrhage into the walls of the bowel found. The abdomens were closed and the patients recovered. There were no cutaneous hæmorrhages at the time, but in one case the cutaneous hæmorrhage occurred some days after the operation, and in the other it had occurred about ten days before the child was admitted and passed off, a fact which shows the importance of inquiring into the previous history of these cases of sudden abdominal symptoms in children. Another case is recorded in Pediatrics, November, 1896, in which a girl aged 7 had a severe attack of Henoch's purpura and also intussusception, the latter not being diagnosed but revealed by the autopsy. It has been suggested that the colicky pains and intussusception are due to hæmorrhage into the coats of the bowel, causing paralysis and the increased muscular contraction of the adjoining part causes invagination into the paralysed and hæmorrhagic portion. It is obvious that the blood state will very possibly be overlooked if there is no cutaneous hæmorrhage, and it is well to remember that intussusception is very uncommon in children over two years of age.

G. H. FIELD.

Cancer in Kafirs: Suggested Cause.

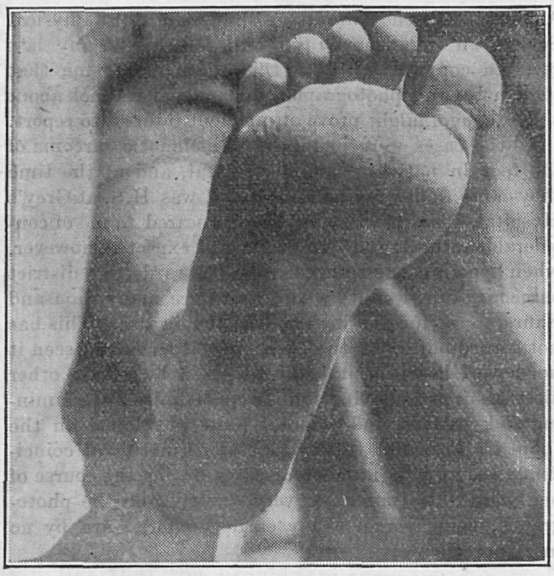
AFTER reading the interesting discussion of the Physical Society on "Cancer Causation," reported in my last received copy of the GAZETTE, it occurred to me that some notes and photographs of cases, which I took about six years ago, might prove of sufficient interest to report.

All the cases were instances of melanotic sarcoma of the foot in natives (Kafirs) of Natal, and at the time they came under my notice, when I was H.S. at Grey's Hospital, Pietermaritzburg, they appeared to me of considerable interest and significance. I expected, however, when appointed, as I was shortly afterwards, to a district surgeoncy in a locality where there are many thousand Kafirs, to see further instances of the disease. This has not turned out to be the case, for neither have I seen it nor have I heard of it being observed by certain other district surgeons having similar opportunities of examining sick natives, and whom I have questioned on the subject. It was, I think, therefore, a matter of coincidence seeing this number of cases during the course of one year. The notes are very scanty, and the photographs, being some of my earliest efforts, are by no means excellent.



Of the two figures on the one photograph, the man with the ulcer on the foot was admitted to hospital on March 18th, 1898, with this condition, the black pigment around the ulcer showing much more markedly than in the photograph; he had also a scurvy-like condition of the gums. The ulcer was excised by Dr. Allen, visiting surgeon to the hospital, on May 4th, and he was discharged on July 6th, but on the 22nd of the same month he was re-admitted, the condition being much the same as in the first instance. This time the ulcer was cut deeply from the muscles in the sole of the foot where sarcomatous-looking material penetrated. Large

masses of glands, which were pigmented in places, were removed from the corresponding groin, the hæmorrhage being very profuse. He died on November 22nd.



On a post-mortem examination the liver and lungs showed nodules of sarcoma disseminated throughout; the former having become three to four times its normal size.

The second figure, where the condition has gone to the formation of a tumour instead of ulceration, was admitted June 10th. This pigmented mass, together with the enlarged glands of the corresponding groin, were removed on the 12th, and on the following day this man almost succumbed from collapse, but recovered only to collapse again and die on the 17th. A necropsy revealed nothing whatever in the form of further metastatic deposit to the naked eye, even the glands on the psoas, which in the former case were full of pigment, were here quite pink.

Of the remaining cases, the one, a woman, with the ulcer on the heel, had this removed, but refused to have the enlarged glands taken from the groin; she eventually went out and was lost sight of. Of the case in which the appearance is best illustrated in the photograph, I can recollect nothing very definite, nor have I any notes, but I believe he too had the ulcer removed and was discharged. A fifth case was also seen but refused to be photographed or treated by operation.

Mr. R. W. Middleton, now P.M.O. Northern Rhodesia, kindly took and examined microscopic sections of these specimens for me. His report was:—"The growth shows the structure of a typical melanotic sarcoma. A section cut from a piece of the growth on the foot shows groups of large round cells loaded with pigment to such an extent as to make it difficult to see the exact size and shape of the cells. These groups are freely supplied with blood-vessels but contain little or no connective tissue. The groups are separated from one another by fibrous tissue septa, the vessels of which show greatly thickened coats (this fibrous tissue and the thickened arteries being probably due to continued irritation). The only piece of gland I succeeded in cutting shows a large amount of secondary growth, viz., groups of large round cells with large nuclei and distinct nucleoli, but no trace of pigment. These groups of cells show a distinct alveolar arrangement. This appears to show that the primary growth is due to pigmentary degeneration of a pigment mole, which of course may have been so small as to escape notice."

The cases are, I consider, mainly of interest for the following reasons:—

1. They are the only instances of malignant new growth that I have observed during seven years' residence in Natal, where I have at all times native patients under treatment.

2. All the cases had the disease in the same position.

3. The only other connective tissue tumours seen have been lipomata and fibromata, including keloids, which latter are common in the scars on the backs of old offenders who have received lashes as a punishment. Other fibrous tumours are very common on the lobe of the ear which has been perforated to put in snuff-spoons, ornaments, etc. I have never yet seen a tumour of epithelial type amongst the native races.

4. The soles of the feet of many natives are full of deep cracks, particularly in the dry weather, and I have several times treated this condition.

The above facts with reference to the fibrous tissue tumours, and the possibility that fissures in the sole of the foot preceded the melanotic ulcers may be taken to support the views of those who uphold irritation as a cause of cancer. But it appears to me that the cracks

in the soles of the feet, together with the only instances of malignant disease observed in natives being in this situation, point rather to the more or less hypothetical parasite, which may very possibly be found in the soil, for the site of the disease itself is very suggestive of infection from without.

W. WARNER HENSON,
District Surgeon, etc.
Impendhle,
Natal.

Notes from Skin Outers.

Psoriasis.

Psoriasis is a word derived from the Greek, meaning the "itch." As a matter of fact the amount of itching varies very much in different cases, but psoriasis is seldom irritable except in people of advanced age.

Hebra says, "psoriasis is a disease of the healthy," and Sir Cooper Perry describes the psoriasis "diathesis" as presenting blue eyes, fair, fresh complexion and light hair.

It possesses the following characteristics :—

1. A *chronic* inflammatory disease.
2. Usually *symmetrical.*
3. Prefers *extensor surfaces* of limbs, especially elbows and knees, also scalp and trunk.
4. The patches, which are *well-defined*, round, oval, or irregular, are surrounded by healthy skin.
5. Covered with *silvery scales*, which may be much or little in amount.

The disease commences as small, flat, scaly papules (*P. punctata*), which gradually enlarge and look like drops of mortar (*P. guttata*), which is the commonest form met with in children. When these enlarge still further disc-like patches are formed (*P. nummularis vel discoidea*), and if it continues to spread it may cover nearly the whole body in large irregular patches (*P. diffusa*). If the patches begin to heal in the centre, rings are formed (*P. circuata*), or a serpentine outline may be produced (*P. gyrata*), and these appearances may also be caused, not by central healing but by a serpiginous mode of spreading. Acute cases, with bright red spots and their scales are called *P. acuta*; very obstinate cases with thick adherent scales *P. inveterata*; sometimes the scales are very conical and limpet-shell like (*P. rupioides*).

Most cases of psoriasis of the palms and soles are syphilitic, unless the psoriasis be found elsewhere as well. Psoriasis in these parts must also be distinguished from eczema, which when located here often causes much callosity (tylus).

On the scalp psoriasis must be distinguished from seborrhœa, by the more uniform distribution, and greasy character, of the latter.

As regards pathology, there is much thickening of the horny layer of the epidermis, and the inclusion of air bubbles gives the disease its characteristic silvery scales; the rete is thickened, and there is cell exudation (inflammation) of the upper parts of the corium.

Radcliffe Crocker says there are two theories worthy of consideration as to the cause of the disease: one that it is a neurosis, or tropho-neurosis, the other that it is due to a micro-organism. Practically, however, the cause is unknown. It may occur at any age after five years (Crocker); is not contagious; but is hereditary in a certain proportion of cases. Recurrence is bound to occur in nine out of every ten patients, and this recurrence is especially prone to occur in the spring.

Sex and occupations have no influence. The writer knows of a case where remissions in the skin disease were followed by malaise and rheumatic pains in the joints. It must not be forgotten that psoriasis may attack the finger and toe nails, with great thickening, deformity, and perhaps subsequent shedding.

With regard to treatment, remedies may be divided into (1) *internal*, and (2) *local*; and what may cure one attack may, in the same patient, fail in the next.

Internally.—

(1) The first drug to be tried is *arsenic*, in the form of Liquor Arsenicalis, beginning with ♏iij. *ter die sumenda post cibum*; it is very apt to disagree with some patients, causing diarrhœa, colic, irritation and redness of the conjunctivæ; these unpleasant results may be prevented by prescribing Tinct. Lupuli ʒss., or even small doses of opium, with the arsenic.

(2) *Thyroid extract* may be prescribed in young and strong, but should not be prescribed unless the patient is under constant medical supervision; the dose should not be more than *five grains* daily to begin with.

With both arsenic and thyroid extract, if found to be doing good, the dose may be gradually increased with beneficial effect.

3. *Salicin* or *salicylate of soda* are sometimes of great value, and are strongly recommended by Radcliffe Crocker.

4. Mercury, carbolic acid, turpentine and potassium iodide may also be tried if the above have failed.

Locally.—It is well to first remove the scales with soft soap and a tepid bath. Then apply one of the following :

1. Ung. chrysarobini (remember it stains skin and linen).
2. Ung. picis carbonis (G.H.P.).
3. Ung. creasoti (B.P.).
4. Ung. picis liq. (B.P.).
5. Ung. ol. cadini (G.H.P.).
6. Ung. camph. co. (G.H.P.).
7. Ung. acidi. salicylici (ʒss. to ʒi : the B.P. is only 2 per cent.)
8. Ung. chrysarobini piceum (G.H.P.) (which consists of chrysarobin grs. 10, sol. of coal tar ♏ 10, ammoniated mercury grs. 10, benzoated lard ʒi.), for generalised psoriasis.
9. Pigmentum chrysarobini (G.H.P.) for single patches.

Sir Cooper Perry points out—and it will be well to bear this simple fact in mind—that the best results are obtained by administering both internal and local remedies at the same time.

In Lighter Vein.

A CURATE IS A MAN.

"To show our simple skill
That is the true beginning of our end.
Consider then, we come but in despite.
We do not come as minding to content you—
Our true intent is all for your delight,
We are not here that you should here repent you."

These lines might have been very aptly inscribed on the programme on March 12th, for one was forcibly reminded on this occasion of the play which Bottom the Weaver and his colleagues performed before Duke Theseus and his bride Hippolyta on their wedding night.

I might perhaps state before going further that there is no truth in the report that Mr. A. B. Walkley was refused admission to the Smoker. *The Times* was not invited to be present and the Gazette was the only paper which was represented on this occasion.

When our editor approached me with a request to write the criticism of the above play I refused point blank and pleaded my ignorance on such subjects, but when he explained that ignorance was no excuse and had nothing to do with it, and had never deterred anyone else from writing on these matters I unwillingly gave way and consented to become the Gazette's first dramatic critic. I learned from one or two actor-managers that the one and only duty of a critic was to show a proper appreciation and to bestow only praise, praise, praise; and then I bought a ticket for a shilling and squeezed myself into a back seat because it was the only one I could get.

The play, which was entitled "A Curate is a Man," was described as a melodrama and problem play, and the curtain had not been up very long before every one in the audience was thoroughly convinced that the dramatist for whom the stage society and other kindred spirits have been searching for so long had "arrived" at last. Take the sensationalism of George R. Sims, the realism of Ibsen, the imagination of Henry Arthur Jones, the craftsmanship of Pinero, the epigrammatic cynicism of Oscar Wilde, the humour of J. M. Barrie and the polished wit of George Bernard Shaw, boil them together and take off the scum, as W. S. Gilbert would say, and the result is "A Curate is a Man." I won't discuss the plot of this deeply moving and interesting play, because it was so cleverly constructed, and written with such depth and subtlety that it was impossible to make out what it was all about. But then it must be remembered that I had only a very back seat. As a melodrama it followed closely the lines of such pieces, for villainy, all powerful for five acts, was overthrown by virtue triumphant at the finish. As a problem play it was equally good. The problem was certainly there, and the problem that we had to solve was to find out what was the problem that we had to solve.

Had the author searched the whole hospital instead of a small corner of it he could not have found actors more suited to their parts. There are very few present students at Guy's who can remember Edmund Kean (he died, I believe, in 1833), but those of us who do remember him will readily acknowledge that no such acting has been seen since his days—if it was seen then.

The play opens with a very effective scene between Dr. Pustule and his daughter Porphyria. The Doctor who, in spite of his age, appears to be suffering from chorea, is trying to persuade his daughter to marry the villain of the piece when she really loves the curate, and one can easily imagine that this scene is a very touching one and one which moved the audience strangely. The part of this old Guy's man, Dr. Pustule, was on Saturday in the capable hands of Mr. Eric Sheaf, who reminded one of Sir Henry Irving in his palmiest days—in fact he was more like Irving than Irving himself. The fascinating and winsome Porphyria was played by Mr. F. P. Hughes, with a charm and girlishness that won all hearts; and her entrance was hailed with a chorus of approval by a crowd of junior men at the back of the room. The character of the villain was ably portrayed by Mr. J. E. Collins, whose villainy would have been a thing of extreme delight to a Surrey audience. He did everything that a properly trained villain is expected to do and a little more on his own besides. Such honest straightforward villainy is good to look upon in these dull times. As the Rev. Eustace Mell, the Curate, Mr. Ray Edridge moved the audience to tears at frequent intervals, and in some heroic way managed to prove that a curate is sometimes a man. How he did this it is difficult to say. I can't explain, but then of course I had a back seat. Mr. Hector Cameron, in kilts, was a thing of beauty, and I feel sure that he would have been a source of pleasure even to Mr. T. W. Crossland. He told a very funny joke, with a wonderfully Scotch accent,

and we all laughed till we cried. Very few of us understood either the joke or the accent, but this did not prevent us laughing, and those who understood least were observed to laugh the loudest. Mr. Blake-Odgers and Mr. Percy Litchfield bore the strain of their long and arduous parts admirably and satisfied everybody, including themselves. The same may be said of Mr. G. Wacher who, despite the fact that he was burdened with such a name as Yogi Yashmak, appeared perfectly happy and at ease. Mr. C. E. M. Jones is a child actor of remarkable ability. One word describes him—he was immense The wicked adventuress (whose chief vice seemed to be that she supped at a restaurant) was played by Mr. H. M. Woodward in a marvellous costume and in quite the right spirit—whatever that spirit may be.

The management had not subordinated the acting to elaborate scenic effects, and very wisely no attempt was made to out-do the lavish display associated with His Majesty's Theatre. Each act was staged in a manner that would have delighted the hearts of the Elizabethan Society, and a very happy idea was the labelling of each different scene. They might have carried the idea a step farther, however, and labelled the actors too, and thus have dispensed with the programme, but then of course we should not have had Mr. Sichel's drawing as a memento.

Mention must certainly be made of the curtain raiser. I am not referring to a one act play but to Mr. C. H. Reinhold, who brought the curtain up and down in so masterly a manner as to excite general admiration.

Others deserving of praise were the audience, who kept their seats pluckily to the bitter end.

The loud calls for the author at the conclusion brought forward Mr. Edridge, who admitted his guilt and promised not to let it occur again, after which he retired amidst tumultous applause.

As we left the dining hall after the National Anthem, my thoughts reverted again to the players in "A Midsummer's Night's Dream" to which I referred at the beginning of my article. And when I dwelt on the play we had just witnessed, I cannot help it if the words of Theseus (after watching Bottom's play) would flit through my brain, "Marry, if he that had writ it had hanged himself at the end of it, it would have been a very fine tragedy."

TIMON.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Presentation to Mr. Badcock.

Dear Sir,—May I crave a few lines of your space wherein to express to my dental colleagues my heartfelt thanks for the beautiful old silver salver which was handed to me on Thursday last by Messrs. Maggs, Hopson and Pearce on their behalf, and for the kind words of the address which accompanied it.

That my work at Guy's during the past twelve years has been to me an unfailing source of interest and pleasure has been due, in no small degree, to their cordial sympathy and support, their friendly counsel and never-failing help.

I shall ever treasure their gift, not alone as an article of value, but as a memento of happy days and of friendship which I trust may be life-long.

I should like, also, to take this opportunity of acknowledging the unvarying kindness and goodwill that has been extended to me from the day I entered the hospital, as a stranger, up to the present time, by the staff, the students, and indeed every one with whom I have been brought into contact. They have made my work very easy and very pleasant.

I bid them farewell with many regrets, proud of my associations with them and the great institution which they represent.—I am, sir, your obedient servant,

140, Harley Street, G. H. BADCOCK.
Cavendish Square, W.
March 13th, 1904

Dr. Orloff Combe.

Dear Mr. Editor,—Permit me to call the attention of any of your readers who will recall Dr. Combe, to a fund that is being raised to enable him to resume practice. Taken suddenly ill while carrying on a large practice in Norfolk, he lost the use of the left arm. The cause was looked upon as cerebral, and he was advised to give up hard work. Happily, further investigation shows the cause to lie in the spinal cord (see Sir W. Gower's lecture, *Lancet*, October 10th, 1903). By great perseverance, Dr. Combe has regained the full use of the hand and arm. Subsequently the left hip had to be excised for threatening suppuration with increasing lameness and pain. The osteo-arthritic condition being here probably neuropathic also. For some years the plan of taking resident patients succeeded, but of late, owing to keen competition, this method of earning a livelihood has failed. An excellent nucleus of a practice is offered in the town of Witham, where he has lived since leaving Norfolk, and where he is well known and respected. An effort is being made to raise £250 to £300 to give him a start. The plan has been warmly taken up by many of his old friends and by the medical men in Norfolk.

It is very satisfactory that the medical men in Witham approve of his starting there, and that there is plenty of room for a second practice.

If you will be good enough to open a subscription list, and receive donations, I feel sure many Guy's men will be glad of the opportunity of helping a man who is making such a plucky effort. His cheerfulness and energy are as striking as ever, and he has made many friends in his neighbourhood.

I may add that Combe was equal for the gold medal in the M.D. examination at Edinburgh, and entered Guy's in 1875.

Subscriptions varying from one to ten guineas have already been received, and it is hoped the full amount will be raised in order to secure the practice. A friend has paid the purchase-money, and Dr. Combe takes over the practice on April 1st.—Believe me, yours faithfully,

CHARTERS J. SYMONDS.

14th March, 1904.

[Subscriptions are invited for this most excellent project and should be addressed to Mr. C. H. Wells, Secretary to the Treasurer.—ED.].

The Present System of Treating Fractures.

SIR,—I have read with great interest the paper by Mr. Peall on the treatment of fractures, and also the correspondence in your last issue.

In the first place, I think that everyone who has left the hospital would range themselves against what your correspondent styles a "three man" treatment. It is often very difficult to get assistance which can with any regard for truth be classed as intelligent. Again, without constant use it is not easy to make a good plaster splint, especially if one has to rely on the local plasterer for a supply of plaster of Paris. Seeing the difficulty of getting good assistance, and the risk of the plaster not setting well, which I think many would honestly acknowledge, it seems to me that the immediate use of a plaster splint is not the best method to employ, say, for a Pott's fracture, in general practice.

I think most people who have tried the results of massage and early movement will quite agree with Mr. Peall. Having tried several methods, I find the most useful to be as follows: Put up the leg on a back splint with a movable foot-piece of the usual kind and side splints, but leaving room for the foot-piece to be moved several inches away from the foot when massage and movements are to be started. The ankle can be thoroughly massaged and moved, and plaster can be applied at the end of a fortnight.

When Mr. Peall advocates the use of a Croft splint I must disagree with him. It has academic interest but has no advantage over a Bavarian. The latter is easier to make, and fits better. A fortnight after the fracture it may be applied with the help of anyone and there is no risk of the plaster beginning to set before getting the pieces in situ. I cannot believe also that a satisfactory splint is obtained when a roft has been applied over a swollen ankle and that "after all the effusion has been absorbed all that is necessary is to bandage the splints more firmly together."

Turning to fractures of the humerus, I quite agree that massage is of the greatest use, but why abandon the use of splints? The results of fractures here have been for the most part good, except when complicated by dislocation. It could not be said that non-union was due to too much immobilization. Massage can well be applied to the shoulder and slight movements instituted while the limb is on an external angular splint, and at any rate a poroplastic shoulder-piece can do no harm in the intervals.

The best result I have ever seen in a fracture involving all the bones of the elbow-joint was treated by extension on the Hodgen principle, and moved at the end of a fortnight with the best results.

In conclusion, may I with your correspondent put forward a plea for the teaching of homely methods which are in danger of being lost sight of in these days when the inventor has become a burden.—I am, sir, yours faithfully,

DUDLEY G. GREENFIELD.

Rushden.

Pupils' Physical Society.

THE last meeting of the Session was held in the Smoking-room on Saturday, March 19th, at 8 p.m., with Mr. Mollison in the chair.

The chairman announced that the Society's Prize had been awarded to Mr. N. I. Spriggs for his paper on "The Diagnosis and Treatment of Coma." Mr. J. S. Cooper was then called upon to read the Treasurer's Prize Essay on "The Uses of Electricity and Light in Surgery." Mr. Cooper was warmly congratulated on a very interesting and judiciously critical paper.

Messrs. Blake-Odgers, Peall, Goss, Mann and the Chairman joined in the discussion, and Mr. Cooper having replied, the meeting terminated at 10 p.m.

Specialities.

A New Fire Extinguisher.

WE have pleasure in directing attention to "The Royal *Fire Extinguisher*," an illustration of which will be found in our advertising columns. This apparatus has been tested at Guy's with quite satisfactory results. It is, as its makers claim, both simple in construction and effective in operation, and possesses many advantages over ordinary fire buckets. Being easily handled and attractive in appearance, it is well adapted to the requirements of private dwelling-houses as well as hospitals and institutions.

The makers, Messrs. Fry & Co., Ltd., Peninsular House, Monument Street, London, E.C., will supply full particulars on application.

Case of Recurrent Attacks of Jaundice. Operation. Removal of Gall-stones. Cholangitis. Recovery.

W. P., æt. 44, married, was admitted into the medical wards for "jaundice and pain across the abdomen."

Eight or nine years ago she had very bad pains across the stomach, accompanied by constipation and jaundice. Since that date she has had an attack of jaundice every three or four weeks, accompanied by weakness and diarrhœa, her motions being very pale. The condition of her bowels alternated between constipation and the reverse. She attended Out-patients for three weeks previous to admission. She stated that she was always rather yellow, but had never to her knowledge passed a gall-stone. At times she suffered from intolerable itching of the skin.

A fortnight before admission, it is stated that she had a chill, and next day felt pains all over the abdomen. These gradually got worse and she became increasingly jaundiced, the pains being continuous. A period of diarrhœa was followed by obstinate constipation. She had a fainting fit which lasted for half an hour.

When she was admitted she was yellow, emaciated, and rather cachectic; the liver did not appear enlarged and the pulse was slow and regular, 63 to the minute. There is no note in the report concerning a tumour in the region of the gall-bladder.

On December 19th, Dr. Beddard saw the patient, and diagnosing a condition of gall-stones obstructing the common duct at intervals, advised operation. Accordingly on January 7th, Mr. Symonds, having seen the patient, decided to attempt to relieve her condition. She was therefore transferred to Esther private room.

Ether having been given on a Rendale's mask, a vertical incision was made five inches long from the eighth costal cartilage along the rectus muscle, which was split along its outer border.

The peritoneum was next divided for a distance of three inches. The operator then inserted two fingers, and, turning up the lower edge of the liver, after some difficulty located the gall-bladder. There were extensive adhesions between this structure and the liver, on tearing through which the latter came into view. The general peritoneal cavity being protected with sponges, the gall-bladder was opened by a vertical incision close to the common bile-duct, and two large stones were removed from the cavity, and from the common bile-duct. This latter was found to be much dilated. Some smaller stones were now scooped out and a drainage tube passed up into the liver. The hepatic duct was very dilated, and there was a large cavity some two inches in diameter into which the above mentioned tube was inserted. This was connected with a catheter and carried outside the dressings. Another tube surrounded by a gauze tampon was inserted into the peritoneum in order to drain any bile that leaked past the first tube. The gall-bladder was partially closed with sutures as was also the abdominal wall, and dressings were applied.

Thus, at the end of the operation there was one tube passing up the hepatic duct into its dilated portion, and another passing down to the gall-bladder, this latter being surrounded by a gauze tampon.

Next day the patient was fairly comfortable; there was free discharge of bile from the tamponed tube, but not much from the one which passed up into the liver. This condition continued for a week, her temperature, however, never fell to normal, averaging between 100° and 101°; her pulse, too, which had been slow before the operation was now usually 100. The discharges from the wound, which consisted of bile, were most excessively foul. Still, on the whole, her condition was not such as to cause much anxiety. She seemed brighter and more cheerful. On the 20th, however, her temperature rose to 102°, and the discharge being exceedingly foul the tampon was removed, and fresh gauze inserted, the tube being omitted.

At this period her motions were light in colour and her urine contained much bile. Her jaundice, curiously, showed no signs of diminishing, and her pulse-rate seemed inclined to rise.

No improvement manifesting itself in her condition on the 26th, Mr. Symonds saw the patient again, and on carefully examining her made the following notes:—

(1) The jaundice was deepening, and the temperature rising, and this in spite of a free escape of bile. (2) A No. 6 catheter passed easily along the track of the drainage tube for seven inches from the skin, and then entered a large cavity after traversing a stricture. A No. 12 catheter was passed, gripped tightly and left. (3) Bile had an unpleasant odour, but no foul mucus could be drawn through the catheter. (4) Right lobe of liver could be felt at the level of the umbilicus, but the abdomen moved freely and was not distended. The spleen was not palpable. (5) There was no evidence of pneumonia but the liver seemed to rise higher than normal.

He accordingly concluded that there was a condition of septic cholangitis, but discussed the possibility of—(1) A calculus being present in the large dilated cavity above mentioned, blocking some of the ducts, or (2) of a stone being still impacted in the common duct, a sacculus of the gall-bladder having been mistaken for the common duct at the operation. Subsequent events proved his conclusion to be right, and cholangitis to be present.

He recommended that the catheter should be syringed with saline solution daily. This was done and an immediate improvement manifested itself, for on the 27th the temperature fell to normal and the patient's condition was much improved.

From this time steady progress was made until February 9th, when again the temperature rose and remained up for three days. The jaundice, which had never quite disappeared, again became evident; she seemed worse generally, and the odour from the bile

again became marked. There was also a slight amount of pus evident at one end of the wound.

Mr. Symonds, reconsidering the conditions, determined to try syringing again. This being done, and the patient having a rigor, apparently consequent upon the reintroduction of the catheter, he determined to operate. He announced his decision on the Friday. The patient was very much opposed to having anything further done, and apparently made up her mind to get well, for from that moment her temperature came down, her jaundice decreased, and on Monday Mr. Symonds resolved not to do anything further, and at the present moment she is nearly well, with the bile disappearing from the urine, the fæces becoming normal, and the general languor and emaciation giving way to energy and good nutrition, although there is still some discharge from the biliary fistula.

The interest of this case lies: (1) in the septic cholangitis giving symptoms of obstructive jaundice, and (2) in the rapid recovery from the last attack, due apparently to the determination of the patient not to undergo operation. C. R. H.

Dental News.

The Board of Examiners in Dental Surgery of the Royal College of Surgeons of England, on account of many candidates who have only passed in the dental part of the L.D.S. examination, not presenting themselves for the general part, brought this fact to the notice of the Council of the Royal College of Surgeons, who with a view to obviating this, adopted the following resolutions, to come into force after November 1st, 1904.

1. That a candidate who elects to take the examination in two parts must present himself for, and pass in, the general section first.

2. That a candidate who presents himself for the whole of the examination, at the same time, may pass in the general section, though he may fail in the dental section.

3. That a candidate who presents himself for the whole examination, shall complete his examination in the general section before his dental paper is read by the examiners, and before being admitted to the Dental Practical and Oral Examination, and, in the event of his failure in the general section, he shall not be allowed to proceed with the dental section.

4. That in the event of the compulsory withdrawal of a candidate from the dental part of the examination, the fee paid for admission to that part will not be forfeited by him, but will be held over until such time as he becomes eligible and presents himself to be examined by the Dental Section of the Board.

The Board of Examiners were also authorised to hold an additional examination in the general section of the examination in February, 1904.

The regulations have also been so modified that men joining the hospital in October will be allowed to present themselves for the general section only, at the examination held in the May twelvemonth after their joining, *i.e.*, after they have completed two winter sessions instead of two whole years as before.

This last modification is a reversion to the regulations for students who registered before January 1st, 1897, but as under those regulations the examination was not divided into dental and general sections, and as two years at a dental school were required before the candidate was admitted to the examination, this new regulation is really more advantageous from the student's standpoint. This alteration does not of course apply to men joining in May, and we shall therefore probably see the October entry increase, and the May entry diminish in the near future.

Reviews.

The price of books submitted for review should in every case be stated.

Midwifery for Midwives. By Dr. Denison Wiggens.

This manual, which is intended to prepare candidates for the London Obstetrical Society's licence for midwives, appears to us to fulfil its scope admirably.

We especially like the chapters dealing with asepsis, general nursing, and infant feeding. If there is too much in the book for the average midwife, or too little for the highly-trained nurse, it is clearly the fault of the Obstetrical Society, and not that of the author, whom we must congratulate on his effort, even though we must disagree with him when he suggests that beeftea is a food.

We can heartily recommend this book to the hard-worked nurse who wishes to become a qualified midwife, but who has not got the time or perhaps the inclination to read the larger books. The oncoming extern, too may do much worse than read this book. The illustrations by an old Guy's man fulfil their purpose well.

Drugs: Their Production, Preparation and Properties. By H. Wippell Gadd. Crown 8vo, 192 pp. (Balliere, Tindall & Cox, 5s. net).

A small work intended for pharmaceutical students preparing for exams., and as a supplement and summary of regular teaching. Its chief claim to recognition must lie in its brevity, if such can be considered an advantage in a book on this subject.

Generally the name of the drug is followed by a few lines on its distribution, the parts used, and any point of interest, and then the different preparations are described.

Pass List.

University of Cambridge, March, 1904.

DEGREE OF M.B.

H. Ackroyd, J. H. Donnell, C. M. Murray.

Sport.

Inter-Hospital Assault at Arms.

Competition for the Boxing, Fencing, and Athletic Cups.

On Friday, Feb. 26th, ultimo, after ten years, during which time it has lain in abeyance, the competition for the Inter-Hospital Boxing and Athletic Cup was revived at the German Gymnasium, King's Cross, and judging from the enthusiasm with which the various items were received, it may be safely predicted that it is not likely to be allowed to lapse again.

There is a mystery attaching to the original trophy, which, when last competed for, was won by University College. The latter, however, when challenged this year, and invited to produce it, disclaimed all knowledge of its whereabouts, with the result that it was found necessary to purchase a new one. This was done, and it now ornaments the walls of the smoking-room of our friends at the London Hospital.

The competitors were London, Guy's, St. Thomas's, and St. Bart.'s: London in the end beating Guy's by 11 points to 9, Thomas's being third with 8, and Bart.'s fourth with 5.

The arrangements which were in the hands of Messrs. Burgess and Minett, could not have been improved upon, the bitter cold being the only thing they seemed unable to control. And though the length of the programme necessitated the business being continued to a late hour, there was hardly a dull moment throughout, the boxing, of course, as usual, creating the most enthusiasm. Indeed, one rarely sees such excitement as was shown during the last contest of the evening, the final of the heavy weight competition between Jones and Wakefield. Jones, who had had a very gruelling bout with Young in the first of the series, being beaten by Wakefield's exceptional pluck and stamina.

A detailed account of the separate events is appended.

BOXING.

Feather Weight, 1st Series.—A. H. Burnett (Lond.), a bye. W. S. Edmonds (Bart.'s) beat H. Russell (Guy's). Russell was plucky and stuck well to his man, but was outclassed by a taller man with a longer reach, and a clever boxer. Finals.—W. S. Edmonds beat A. H. Burnett. Edmonds, much the cleverer of the pair, made good use of a straight left and won easily.

Light Weights, 1st Series.—H. E. Perkins (Guy's), a bye. S. C. Langford (Bart.'s) being over weight. E. L. Atchinson (Thomas's) beat H. L. Pidy (Lond.) Atchinson, a smart two-handed boxer, with what the sporting papers describe as a "nasty punch," bustled Pidy about most of the time. Pidy, however, made good use of his left, but has an unfortunate habit of dropping his head forward as he leads, which Atchison took every advantage of. Finals.—E. L. Atchinson beat H. E. Perkins, Atchinson immediately set about his man. Perkins, however, responded nobly, but something appeared wrong with the Guy's man, who seemed to have lost all his "vigor and vim." Indeed, it transpired later that Perkins was very unfit to box. Towards the close of the first round Atchinson sent in a right-hander which dazed Perkins. In round two, Atchinson's right-handers seemed to bother Perkins considerably; one of them ultimately landing well, finished the matter summarily in Atchinson's favour.

Middle Weights, 1st Series.—R. Burgess (Lond.) beat H. C. Squires. Squires is one of the swinging, bustling school, met in Burgess a cool, steady, and very clever boxer, and though there wasn't much in it at the end of the first round, from that out Burgess rapidly piled up points, winning well in the end. P. Gosse (Barts.) beat T. E. A. Carr (Guy's). Gosse, whose prancing movements excited considerable amusement, did not seem at any time to have the best of matters. Carr boxed steadily, but was obliged to spend most of his time running round the ring after his opponent. The referee gave the verdict to Gosse. Finals.—R. Burgess, a walk over. Gosse withdrew.

Heavy Weights, 1st Series.—C. E. M. Jones (Guy's) beat F. P. Young (Bart's.) A rattling contest, in which both banged each other about severely; Jones was generally quicker; Young kept close and landed hard and often. Both were considerably done up at the end. A. W. Wakefield (Lond.) a bye. Finals.—A. W. Wakefield beat C. E. M. Jones. Jones' blows had no sting in them, and though he landed by far the most frequently in the first round, he could make no impression on his opponent. In the second round, Jones showed the effects of the first contest, and tired rapidly. Wakefield (who looked more like a middle than a heavy weight) noticing this, never gave Jones a second's rest, but kept close and banged away, ultimately winning an extremely plucky victory. The points allotted for the boxing, were two for the runner up, and three for the winner. Hence London scored 8, Bart.'s 5, Guy's 4, St. Thomas's 3.

FENCING.

1st Series.—R. G. Reynolds (Guy's) beat H. C. Glover (Guy's). A close thing, Glover scoring 4 to Reynolds' 5. P. A. Adams (Lond.) beat A. C. Suman (Thomas's). A pretty bout, both men being clever. Finals.—P. A. Adams beat R. J. Reynolds. Adams much the cleverer, won by 5 to 2. For second place, Suman beat Reynolds; the score thus showed, London 3, St. Thomas's 2.

SINGLE STICK.

This was conducted on the pool system, the points allotted being 3 to the winner. Sutcliff (Thomas's), Downs (Bart.'s), Gray (Lond.), and Mills (Guy's), being the competitors; Mills winning, being beaten only once, and so securing three points to Guy's.

GYMNASTICS.

The exercises were on the bar, rope, vaulting horse, ladder and rings. The scoring was as follows:—

St. Thomas's.—C. Bennett 87, L. Fyffe 76 = 163.
Guy's.—S. Reader 68, H. Dyson 76 = 144.
London.—E. L. Sandiland 73, A. C. Martin 63 = 136.
Bart.'s.—R. S. Haines 86½, W. R. Square 41 = 127½.

Haines would have had the top individual score, but he missed his footing in the take-off at the vaulting horse and had to go back. This cost him a point, so making his score half a point less than that of Bennet. The scores for this competition working out at—Thomas's 3, Guy's 2, as only aggregates counted.

Association Football.

Guy's v. Charing Cross.

Inter-Hospital Challenge Cup.—Final Tie.

History, so far as Guy's is concerned, did not repeat itself at Queen's Club on March 16th. In 1900-01—the last occasion on which the final was played there—the result was Mary's 2, Guy's 0. This year we won. The ground was in excellent condition, though the ball appeared at times to be unpleasantly lively. Guy's won the toss and took advantage of a slight wind which blew

straight into the grand stand." Charing Cross lost possession from the kick-off and Barber and Litchfield worked well down before they were pulled up by the Charing Cross backs. It was soon evident that our opponents' efforts would be confined to the typical cup-tie rushing game. Play soon settled in the Charing Cross half of the field, and Litchfield, getting through, sent across to Piper who scored a good goal after ten minutes' play. The Charing Cross forwards came away from the centre kick, and gave our defence rather an anxious time. Edwards and Crockett, on the left, were very well stopped by Plummer, and then Collins had to clear a shot from a run by Hicks and Badcock. Litchfield had very hard luck with a drive which just went outside, and near half-time Barber ran through and should have scored easily, but failed badly with his shot.

The second half opened with a long attack by our forwards. The Charing Cross defence was quick and very persistent and eventually succeeded in setting its forwards going. Plummer repulsed the left wing in great style, but the ball going out to the right soon after, Rodgers sent in a centre which was only half cleared, and the ball going out to Badcock, he put his side on level terms. Nettled by this state of affairs our wing forwards pegged away in grand style, and centres by Piper and Wragg both went begging in the most lamentable fashion. The Charing Cross defence stood the attack well at first, but later on failed to smother a lovely centre of Wragg's, which Piper promptly banged past Ball, and soon afterwards Mr. Pat Harrowen whistled "the last post," leaving Guy's to retain the Cup for another season.

Guy's v. St. Thomas's.

Junior Association Cup Semi-final.

This match was played on the ground of the latter. We won the toss and St. Thomas's kicked off, the play being fairly even, although we obtained two or three corners we were unable to score. St. Thomas's broke away but were repelled by Zorab, who, placing the ball beautifully in front of goal, Wearing netted. Soon after, from a good centre by Witts, L. Jones put us two up. St. Thomas's now broke away, but Wearing got the ball and cleverly eluding the backs scored number three. Half-time 3—0.

On the restart, A. Jones got through, but missed kick, L. Jones put through, but was ruled off side. We were then awarded a penalty which was missed. A slight alteration was made in our forward line, and after some nice combination Witts scored. The last player, helped by Wearing, scored again soon after. Just before time from a fine centre by H. Jones, Wearing scored his third goal with a fine shot. Result 6—0.

Remarks.—The backs were very safe and the halves fed their forwards with good judgment. The forwards themselves were very weak in front of goal.

United Hospitals Hare and Hounds.

A match against Oxford University (who, owing to the close proximity of the Varsity sports, were really running an A team) brought this season's fixtures to a close. Unfortunately three of our men missed the trail, otherwise we ought to have just won, judging on the form shown in the inter-hospital race. Result:

			min.	sec.
1.	A. L. Chandler	Bart.'s ...	48	15
2.	W. H. J. Griffith ...	Brasenose ...	48	33
3.	T. E. A. Carr	Guy's ...	48	57
4.	W. T. S. Sonnenschein	Christ Church	49	8
5.	K. Bell	Balliol ...	49	48
6.	R. W. Hill	Merton ...	50	39
7.	R. E. W. Chafy	Christ Church	51	59
	H. Stott	Guy's ...	lost trail.	
	V. Townrow	Guy's ...	do.	
	M. Adams	Guy's ...	do.	
	S. G. Tallents	Balliol ...	do.	
	C. A. W. Aglen	Keble ...	retired hurt.	

Hockey.

Inter-Hospital Competition.—Final Tie.

Guy's v. Thomas's.

Played on Monday, March 14th, on the Athletic Ground, Richmond.

This match was played on the same ground as in the semi-final with Bart.'s on Thursday, and ended in a win for us by 3 goals to 2. Thomas's pressed at the outset, and in the first ten minutes scored through West, who at inside right was always dangerous and had to be closely watched. Soon afterwards the same player dribbled through and missed an open goal. This seemed to rouse us, and for the rest of the first half we had slightly the best of the game, and a good shot by Wells from the edge of the circle made matters even. Although frequently dangerous, several corners being forced, we scored nothing further up till half-time, and the teams crossed over with the score at 1 goal each.

From the restart Thomas's broke away, but were sent back, and some good play by Wedd enabled Wells to put us ahead. The game was very even, but Davies soon increased our lead with a third goal from a scramble in the circle. Guy's were now winning, but about eight minutes before the finish West secured the ball and going through added a second goal for Thomas's with a fine shot, the defence being rather taken by surprise. Thomas's now made big efforts to equalise, and pressed hard, but being unable to do so Guy's ran out winners.

Remarks.—The forwards on either side did not combine so well as on last Thursday, but made up for this deficit by more individual dash and keenness. Wedd was easily the best, and it was chiefly through his agency the goals were scored. Wells, as usual, was very good in the circle, while Davies made some capital runs. Leckie was a host in himself at centre half, and got through an immense amount of work, and was ably backed up by Langdale and Norton; Knight was very sound at back, while Archer, although making some capital clearances, was not so safe as usual. Nicholson-Smith was very safe in goal. This is the first time Guy's have won this competition, since its inception five years ago, and with the prospect of running a regular team next year, it should not be the last.

Marriage.

WORTHINGTON—MORICE.—On March 10th, at St. Michael's, Chester Square, by the Rev. Canon Fleming, Harry E. Worthington, M.R.C.S., L.R.C.P., The Sycamores, Birchington, son of the late G. Worthington, M.D., M.R.C.S., of Thorncliffe, Bournemouth, to Muriel Rose, only daughter of C. J. Morice, Esq., of 28, Belgrave Road, S.W., and Sandown, Isle of Wight.

Ed.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 416.] APRIL 9, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	141–143
Common Forms of Internal Ear Deafness. Clinical lecture by Mr. C. H. Fagge ...	144–150
A Case of Malignant Endocarditis treated with Antistreptococcic Serum. Recovery after 4 months	150
Blue Urine	150–151
In Lighter Vein	152
Notes from Skin Outers	153
Change of Address	153
Case for Diagnosis	154
Papers by Guy's Men	154
Pass List	154
Appointments	154
Correspondence	155–156
Notices	157
Reviews	158–159
Sport	159–160

Passim.

ALL our readers will be glad to hear that Sir Samuel Wilks is improving rapidly. He gets up and walks round the room, takes food well and sleeps naturally. Mentally he is recovering his power and discusses "anatomical and physiological" theories in his old way. There is still some confusion in his memory with regard to his illness, but considering the marked advance in the last week there is every prospect of complete recovery.

THOSE who, owing to work in the wards or coming exams. were obliged to remain at their posts during Easter, complained that the Hospital was at that time a very dreary place indeed. It is becoming more and more the custom to get away from town at this season, and Guy's men seems as anxious as anybody to join in the general exodus. Certainly those who were fortunate enough to get away for a few days had no cause to complain on the score of the weather. The Fates were on the whole propitious and gave us typical April weather with as much sunshine as we have any right to expect at this time of the year. Shakespeare speaks of—

"The uncertain glory of an April day,"

which proves that in spite of the declaration of many that the seasons are altering, April at any rate remains pretty much the same as it was in William's days.

OUR readers will all learn with regret of the death of Mr. Malcolm McPherson, which took place at Newcastle on March 30th. He entered Guy's in 1902, coming up from Clare College, Cambridge, and during the short time he had been a student here he made for himself a large number of friends. He was attended in his illness by Dr. Lane, of Newcastle, an old Guy's man, who describes him as one of the most patient men he ever had under his care.

THE "Going-off" dinner of the Residents, which was held in the dining-hall on Wednesday, March 30th, proved in every way as successful as those of former occasions, and a large party of friends and well-wishers were present

to drink the toasts and join in the speeches that are always part of the evening's entertainment. The Residents who retire this month, are Mr. George Evans, Mr. D. T. Trail, Mr. C. R. Howard, Mr. Blake Odgers, and Mr. T. Morland Smith, and they could certainly not complain of the hearty send-off which was given to them. There has seldom been a more popular President than Mr. Evans, and his loss will be felt not only by the Residents, but by a very large number of friends whom he has made in the Hospital. We feel sure that he and his colleagues carry away with them the very best wishes for the future. Mr. Evans' place as President is taken by Mr. Glendinning, and Mr. C. H. Reinhold succeeds Mr. Trail as Vice-president.

Lovers of old customs are regretting that the supper in the Dressers' room looks like becoming a thing of the past. The alteration in the Front Surgery, and the destruction of the old room which has been the scene of many convivial evenings, has necessitated a change in the dressers' abode, and this is mainly responsible for the smaller number of men who patronise the place. The old room, at any rate, had the advantage of convenience, but the present one is so out of the way and difficult to get at, that there has been during the last few weeks a marked falling off in the number of men who were in the habit of dropping in for a smoke and a chat, and who finished up by making a night of it. The death of old customs is always deplored by some, whilst to others the quiet dulness of the present dressers' room is looked upon with a certain amount of satisfaction. Whilst preferring not to express an opinion either way, we can certainly sympathise with our correspondent—whose letter we print this week—who appears to have a legitimate cause for complaint. In order to provide a room for the dressers, the authorities have appropriated one of the bedrooms for that purpose, and have omitted to provide another bedroom to take its place. The result is that there is only one bedroom for the two dressers, who are in consequence expected to occupy the same room. The writer of the letter to which we refer has put his case very effectively. It is certainly hard if you have to share a room with a man you may possibly dislike, and even if this is not the case, it is not pleasant to be disturbed in your sleep every few minutes, perhaps when it is your turn to get a well-earned and much needed night's rest. Since the new arrangement came into force the dressers have taken alternate nights in the College, but if neither of them has a room there, it frequently happens that there is a difficulty in obtaining one, and even then it has to be paid for. To obviate this, a room might surely be set apart in the College for the dressers, as it is for the externs, and this would no doubt do away with the dissatisfaction which is so freely expressed on all sides.

We have great pleasure in acknowledging the receipt of one guinea from "G. F. H.", which is sent in response to the appeal of Mr. Symonds, whose letter on behalf of Dr. Coombe Orloff appeared in our last issue. Donations towards this fund, which has been started in aid of an old Guy's man, may be sent to Mr. C. H. Wells, at the Treasurer's office.

The plague in Johannesburg has been causing serious alarm to some, and the Colonial Secretary was asked by a member in the House whether it would not be advisable to send out some experienced bacteriologist to investigate the matter. Mr. Lyttleton replied that he had heard from Lord Milner on the subject, who wrote to say that they had a very effective staff there already under a clever and experienced bacteriologist in whom they had all the greatest faith. Guy's men will be interested to learn that the Colonial Secretary referred to Dr.

The Davies-Colley Memorial Book Plate.

Pakes who, it will be remembered, left the Hospital about two years ago to take up the post which he now fills so satisfactorily as to call forth the above praise from such a high quarter.

There are, we believe, a good many present students in the Hospital who have very little idea as to the progress we are making in the Electrical Department and what is being done in the way of the Light Treatment. We read a good deal of the London Hospital in relation to this subject, but when our new Electrical Department (which is to be near Samaritan ward) is fitted up we shall run them very close indeed. This department will be under the care of Mr. Gerald Sichel and will include electric and hot air baths and the Finsen Light apparatus. Many new features have lately been introduced into the Electrical Department, which is well worth a visit. Among these are the Harnac lead glass shield for the X-Ray tube and the carbon arc lamp, which is a small but complete set of Finsen's Light apparatus, which, together with the advantage of its very small size, claims to be very much superior to the old method.

The sixpenny gate at Honor Oak Park has proved a great success, £60 being the net result this season, which is twice the amount that was taken last season and also of the season previous to it. In October to March, 1902–1903, £27 was the sum taken at the gates to witness the more important matches, and this has been more than doubled in the season which has just finished. The numbers who paid for admittance have not diminished, but have slightly increased in spite of the extra charge, and the Committee have reason to congratulate themselves on the satisfactory financial result.

He was a Ward Clerk in the Front Surgery, and the other day he walked with some dignity to a small boy aged eight, who had just entered, and tenderly enquired what was his trouble. "Please, sir, I've come with my arm," piped the small urchin. "Well, you couldn't very well come without it, could you?" replied the clerk, facetiously; and he appeared pleased when he noticed that the other occupants of the bench smiled at his witty remark. "I dunno so much about that," replied the urchin, promptly, "'cos sposin' the cart what knocked me down had taken off my arm, what then?" The smiles on the faces of the other patients developed into a laugh, and the clerk suddenly became very busy, and wisely attempted no more witticisms at the expense of the little logician.

The British workman has been well in evidence in the College lately, and the work of papering the walls is proceeding in the dignified and leisurely manner which is so typical of that individual. The corridors are already looking brighter and cleaner, and for this we must try and forgive the weird ugliness of the paper. We know to our cost that it might have been worse than it is, and to prove this we have only to walk into the Smoking-room. For when we look at the two colours with which the walls of that room are painted words fail us.

This is an age of Competitions. Even the *Times* has lately succumbed to the fever, and now it is the turn of the Gazette. It has often been suggested to us that a competition of some kind would prove of interest to our readers, and we have decided upon one which we hope will commend itself to all, and give everyone an equal chance of the prize. It will not be one that will necessitate any great tax on the brain, for most men here consider that their brains have quite sufficient to do as it is; nor will the solution demand a great expenditure of time, for that, too, would prove a serious drawback. It will be simply —— but full particulars will be announced in the next issue of the Gazette.

Common Forms of Internal Ear Deafness.

CLINICAL LECTURE BY MR. C. H. FAGGE, March 7th, 1904.

GENTLEMEN,—In the last three lectures we have discussed the diseases of the middle ear, which, from the mere fact that very often they can be satisfactorily treated by operation, are at first sight far more interesting than diseases of the internal ear. Perhaps to-day, when we come to the end of the lecture, you will have a feeling of disappointment at what I shall have said with regard to treatment, and perhaps more so with regard to prognosis in these diseases of the internal ear, but I think there is a great deal of value in practice in being able to give something like a correct prognosis, even if it is a bad one.

Before discussing the diseases of the internal ear, I want to draw your attention anatomically to the eighth nerve. The first diagram on the board shows the peripheral distribution of the eighth nerve after its exit from the pons; you see it passing into the internal auditory meatus with the pars intermedia and the facial, and then the vestibular bundle of the nerve receives part of the pars intermedia, all of which it probably gives back to the facial, just before the latter is enlarged at the geniculate ganglion. Tracing the two parts of the eighth nerve further we find that the upper or vestibular bundle passes to the maculæ acusticæ of the utricle and of the external and superior semicircular canals, while the lower or cochlear bundle terminates in the hair cells of the organ of Corti in the cochlea, in the saccule, and also gives fibres to the posterior semicircular canal.

Our second diagram shows the central connections of this nerve. Let us trace first those of the vestibular bundle, which passes into the brain at the lower part of the pons, travelling to the inner side of the restiform body, and makes its first nuclear connection in the chief vestibular nucleus which lies just under the floor of the fourth ventricle. Fibres also pass into what is called the nucleus of the descending root and into Deiter's nucleus, and though their further course is little known, they are generally regarded as having terminal connections with the roof nuclei of the superior vermis of the opposite side of the cerebellum: that is both vestibular nerves end in the upper part of the middle lobe of the cerebellum. You will remember that the superior and inferior vermes of the cerebellum (the middle lobe) are well developed in lower vertebrates which have no lateral lobes, and are especially well shown in many birds in which the sense of equilibration is peculiarly well marked; an example which naturally comes to one's mind in this respect is the pigeon, in which the cerebellum is unusually large: I want you to associate the vestibular nerve with the middle lobe of the cerebellum and with the function of equilibration.

And now I want you to follow the diagram dealing with the cochlear nerve. Some of the fibres are shown to pass dorsal to the ventral cochlear nucleus, and these fibres go into the lateral cochlear nucleus (tuber acusticum) from which they pass dorsal to the restiform body, across the middle line, into the lateral fillet, and end in the corpus quadrigeminum inferius of the side opposite to that on which they started. Some fibres apparently go to the inferior corpus quadrigeminum on the same side, but I do not know how they go, and I do not find any definite opinion on the matter. The rest of the cochlear bundle enters the ventral portion of the pons to reach the ventral cochlear nucleus and so passes inwards through the superior olive, then it crosses the middle line, being feebly reinforced by the superior olive of the opposite side, to form the lateral fillet, and the internal fibres go to the corpus quadrigemm inferius, while the external fibres pass through the nucleus of the lateral fillet to reach the corpus geniculatum internum, and finally end in the superior temporo-sphenoidal convolution of the opposite side to the ear from which they came: for example, the superior temporo-sphenoidal gyrus of the right side governs the left auditory nerve as far as its cochlear division is concerned. Though in my diagram the lines seem to pursue an unbroken course, we must clearly observe that it is not the one axon of a nerve cell which passes from the organ of Corti up to the temporo-sphenoidal lobe, but each neuron is broken at several points as at the spiral ganglion of the cochlea, the superior olive and the vestibular and cochlear basal nuclei, at some of which it picks up connections with other cranial nerves; for, taking as an example the superior olive, we know that it is intimately connected with the sixth cranial nerve of the same side, and by means of the posterior longitudinal bundle, with the third nerve of the opposite side.

The next thing to consider in discussing nerve deafness is the ordinary course of vibrations passing to the auditory nerve. Probably the

sound waves pass from the air in the meatus to the membrane, the ossicles, the oval window, the labyrinth, to the nerve and centre. If, however, sound be conducted directly through the bone to the auditory nerve, we find that all the parts down to the oval window are replaced by bone, and after that you get labyrinth, nerve and centre coming in again. Now, when we test a case of supposed nerve deafness, we compare the hearing through the meatus and hearing through the bone; we call the meatal conduction Ms, and bone conduction Md. And under natural conditions I think you will agree that Ms is always greater than Md: it is the natural statement that one hears the tuning-fork vibrations better through the passage of the ear than through the bone. It will be quite clear to you that if our premises as to the course of these two sets of vibrations are correct—which they are approximately—that so long as the lesion is placed deeper than the oval window the relations of Ms to Md will be unaltered, Ms will always be greater than Md, because both sides of the equation will be equally affected. So with nerve deafness we find always that meatal hearing is greater than mastoid hearing, the patient hearing the tuning-fork better through the meatus than through the bone: this test is known as Rinné's, the variety demonstrated above, where Ms is greater than Md, being qualified as positive (+) Rinné.

Another test which we have to employ in patients with internal ear deafness is a comparison of the mastoid hearing of the patient with the mastoid hearing of the observer. After making out that the meatal hearing is greater than the mastoid, you put the tuning-fork on the patient's mastoid, and when he ceases to hear it you transfer it to your own mastoid process. You then find that the patient does not hear it so long as you do. We therefore add that mastoid hearing is minus (Md−). I have gone direct to that point because it would take too long to go through the whole line of argument, but you can easily test it for yourself. Take an old man, put the base of the tuning-fork on to his mastoid process, and when he ceases to be conscious of the vibrations transfer it to your own and you will still hear it; which simply means that his perception of conduction of sound through the bone is not as good as your own.

We next come to compare one ear with the other; and this test, known as Weber's, is only of value when one ear is more affected than the other, here, putting the tuning-fork in the middle line on the skull—we generally use the forehead—we enquire in which ear the sound seems the louder, for, for example, it is quite clear that if on the right side the hearing to the watch is 36 inches, and on the left side two inches (*i.e.*, Rt. $\frac{36}{36}$ and Lt. $\frac{2}{36}$), and if Ms > Md on both sides, we should expect Md to be normal on the right side because there is no deafness, and on the left side Ms > Md, and Md −, so if we put the tuning-fork on the top of the patient's head, he will refer the sound in his right ear because bone conduction is defective (Md−) on the left side; that is, there is left internal ear deafness.

I drew you an extreme picture, the nerve deafness being very marked in the left ear, with a normal ear on the right; because if both ears are nearly equally deaf, you will find when the difference between the perception apparatus of the two sides is slight that the patient cannot tell which ear it refers to. This is an extremely valuable test.

So, to recapitulate—in testing a case for "nerve" deafness we should find that the meatal hearing was always better with the tuning-fork than the mastoid hearing. We should find that Md compared with our own Md was —; bone conduction was diminished, and we should find that if there was inequality between the two ears, the tuning-fork was always referred to the better side. The amount of hearing for conversation in lesions of the internal ear is often deceptive, for no difficulty is often complained of when listening to voices, especially the low-pitched tones of male adults, while on testing with the watch or a high tuning-fork, *e.g.*, C_{1024} dv., a great deficiency is found. This brings out the next point I wanted to dwell on—that in lesions of the internal ear high tones are usually lost first, the lower notes following as the diseases advances. Bear this in mind and do not prejudge the absence of deafness in any individual merely because your ordinary conversation is apparently well heard, for the discovery of definite loss to the tuning-fork held on the mastoid may sometimes be of great help in the location of an obscure vertigo or distressing tinitus. This loss of high tones can be confirmed by using a series of tuning.forks, when the loss of mastoid hearing will usually be great with C_{1024} and may even be unnoticed with the ordinary fork C_{256}; another very useful instrument for bringing out this point is Galton's whistle—a form of syren in which a very high note produced by a large number of vibrations should be heard by the normal ear, whereas with marked lesions of the internal ear the highest perceptible sound will fall short of this.

The diagnosis of internal ear deafness can be, as I have said, largely made on the question of the result of the tests I have described. But I would add two or three points. First, people with nerve deafness always hear worse in a noise. Everybody travelling by train has noticed individuals who cannot hear when the train is quiet in a station, but directly the train starts they can join in the conversation. Theirs is not nerve deafness.

With nerve deafness it is not uncommon to have incorrect hearing. Intelligent patients will often say they have incorrect hearing: they commonly hear double tones when only single tones are expressed, so that it is painful for them to go to an orchestral concert on account of the apparent discords. I suppose it is because the two ears are not tuned together, a condition known as diplacusis, just as one would speak of double vision. Sometimes you will find there will be large gaps in the appreciated scale; a certain number of tones from the lowest to the highest will be missed altogether. Of the last two points I want to refer to in this connection, the second is not of much use in diagnosis. The first is this, and it has been several times of value to me: ordinary ear inflation, either by Valsalva's method or by Politzer's method, commonly makes people with nerve deafness worse. Of course often with middle ear deafness the use of Politzer's bag does good, but if you do this for nerve deafness you will immediately make the patient worse for the time being, probably because you depress the membrane in the oval window, and in some way irritate the terminations of the auditory nerve.

The second point was, that the auditory nerve, like all other nerves, has a certain period or length of time during which it can act, and after which it becomes fatigued, and with people with nerve deafness you find the fatiguability of the auditory nerve is very much increased. If one listens to a sound for a certain length of time it gradually dies away; a watch listened to for a long time has to be brought closer, and the nerve is specially sensitive to fatigue for high notes, as you can find by repeated trials with a rapidly vibrating tuning-fork. Always bear in mind that extreme or absolute deafness can only mean a lesion of the internal ear; it may be complicated by middle ear trouble, but cannot be due to that alone: lastly, the high pitched monotone without modulation or expression in which patients with a high degree of nerve deafness speak, may often be a help in diagnosis.

As one would expect from what I said at the beginning of the vestibular nerve in connection with equilibration, vertigo or giddiness, with other anomalies of the equilibrial nerve, such as incorrect appreciation of the relation of the patient's body to other bodies and postural difficulties, are frequent accompaniments of deafness due to the internal ear, and especially so when the peripheral apparatus in the labyrinth is affected. Of course, vertigo results from a number of causes, but Gowers says that 90 per cent. of all vertigo is of aural origin. The characteristic feature of typical aural vertigo is that the patient will tell you definitely he has a sense of movement, either of himself or of surrounding objects, the latter appearing to move towards the affected side, if the trouble is, for the time, unilateral. Further, the vertigo is absolutely unaffected by closing the eyes, and if associated with loss of consciousness at all, it is of extremely short duration. For vertigo to be aural there must always be a loss of hearing, and I think that this is a most important point, often forgotten in attempting to locate vertigo in the labyrinth.

Another very characteristic symptom of internal ear deafness is tinnitus, of which I think the pulsating form is the most common, and it can very often be temporarily controlled by compression low down in the neck. In searching for an anatomical explanation of this, I suppose one would think of the course of the vertebral artery, continued up as the basilar artery from which the internal auditory artery passes out at a right angle to the labyrinth and internal ear through the same foramen as the facial and auditory nerves; from the fact that this artery comes off at right angles with the basilar, on ordinary pathological grounds it would be peculiarly prone to atheromatous degeneration; and so one concludes that most cases of internal ear tinnitus are due to that cause. Tinnitus indirectly due to the internal ear is also seen in lesions of the outer or middle ear. I might quote two examples: where you have a large mass of cerumen or a foreign body blocking the meatus, or where there is a large amount of secretion into the middle ear, with intact drum, either serous secretion, pus or blood, it is natural to suppose the membranes intervening in the round and oval windows between the middle ear and labyrinth would be exposed to an unusual degree of pressure. Tinnitus of cerebral origin is frequent, especially in the climacteric and in neurotics, and must be carefully differentiated from the typical labyrinthine type.

Coming to a more minute diagnosis, it is extremely difficult to tell you which part of the

perceptive apparatus is affected. If you have a general loss of mastoid hearing with the tuning-fork, and the high notes are affected equally with the low, but not more so, then you think of an affection of the auditory tract deeply. If, as is common, the high notes are more affected than the low notes, you commonly find that the disease is in the labyrinth. Where deafness is associated with vertigo you naturally place the lesion in the internal ear, and suspect that the cochlea and vestibular divisions of the eighth nerve are equally affected.

Then often in the diagnosis of which part of the tract is affected we may get some help from associated lesions of other cranial nerves. In the presence of middle ear suppuration nerve deafness with or without facial paralysis usually indicates labyrinthine suppuration, and the same symptoms may be due to a lesion, such as a malignant growth, in the internal auditory meatus. We have in the ward a patient who was strenuously recommended to undergo operation for middle ear suppuration, because we found that on the side affected there was diminished bone conduction, whereas with uncomplicated middle ear suppuration bone conduction should have been increased: the one point here which strongly suggests labyrinthine suppuration is the nerve loss added to the middle ear suppuration.

Another point which suggests it is facial paralysis. I have here a specimen removed from a boy who suffered from chronic middle ear suppuration with nerve deafness and facial paralysis, and it shows the whole of the internal ear, which is sequestrated as a large mass, from the internal auditory meatus to the promontory; such symptoms would naturally locate the lesion between these two points. Internal ear deafness with paralysis of half the soft palate and one vocal cord, would suggest involvement of the eighth, tenth and eleventh by basal pachymeningitis or by leptomeningitis, probably the non-tuberculous basal form. The latter is not uncommon, for I must have seen at Out-patients seven or eight cases in children who, with a disease which was taken to be tuberculous meningitis, have recovered, but became absolutely deaf; and though I have just suggested that some parts of the ninth, tenth and eleventh cranials may be affected in the base of the brain with the eighth, bear in mind that the eighth nerve is curiously vulnerable and may be affected alone.

When the eighth is affected with convergent strabismus of the same eye, due to paralysis of the sixth nerve, meningitis on the under surface of the pons, or a lesion involving the superior olive of the same side are to be thought of. Last December a child was admitted by me into Ruth with a large extra-dural abscess; she did exceedingly well for a time after its evacuation, but later came back to out-patients with a history of convulsions, which we never got to the bottom of, and then we noticed that she had convergent strabismus of the same eye, not marked, but we thought it increased, and Mr. Ormond told us it was paralytic. The dresser was keen on her being brought in and treated, but I could not convince myself that there was a localised lesion likely to be found or benefited by operation, partly for the reason that the optic neuritis which had been produced by the extra-dural abscess continued to diminish. She died in a fit outside the hospital, and there was no post-mortem, but I have often wondered since whether there might have been some meningitis on the under surface of the pons, spreading from the position of the old extra-dural abscess, which had been evacuated for three or four months, and which had again become active. She will serve as a text on which to remember that point. With internal ear deafness and conjugate deviation of both eyes, away from the affected side, you have a lesion of the sixth nerve of the same side, and of the third of the opposite side, which, you will remember, is connected to the sixth by the posterior longitudinal bundle, and which probably means a tumour of the medulla, or of the pons, involving the superior olive.

In other diseases a lesion of the eighth nerve may be of importance, and here is a list of the more common diseases in which you find a lesion of the eighth nerve of some diagnostic value:—

1. Locomotor ataxy—tabetic nerve deafness (auditory nuclei).

2. Cerebellar symptoms (headache, vomiting, optic neuritis) = cerebellar tumour.

3. Bulbar symptoms = glosso-labial paralysis.

4. Quadrigeminal symptoms—blindness, optic neuritis, inco-ordination of eyes, unsteady gait = lateral fillet or pineal or quadrigeminal tumour.

5. Hemianæsthesia and hemianopsia on same side = hysteria or a lesion of posterior part of the internal capsule.

6. Word-deafness = left upper temporo-sphenoidal lobe in the right handed and *vice versâ*.

7. Positive Rinné with diminished bone conduction on the opposite side in temporo-sphenoidal abscess.

I need only refer here to the last two points: (6) word-deafness, in which there is every evidence that the patient hears, but he has no power of cerebrating the sensation, nor appreciation of the word spoken: it is not a condition of absolute inability to hear, but of want of appreciation rather than anything else, and is of some value in the diagnosis of cerebral abscess, for I think that perhaps we do not pay enough attention to such small points, when they might be just the very evidences required to localize an intracranial abscess: again with regard to (7), supposing the patient has left-sided middle ear suppuration and you think he has got an abscess in the temporo-sphenoidal lobe on the left side, if you test his right ear with the tuning-fork you may find that he has got diminished bone conduction to the tuning-fork on the right side, because the superior temporo-sphenoidal lobe on that side is pressed upon or inflamed, so that the cochlear fibres are not performing their functions naturally. I simply offer that list as a plea for all of you who are in the wards to discuss the auditory nerve. Again, it is a common, and often a lamentable omission not to test the auditory nerve in the wards in those cases in which a fractured base is suspected: only a few weeks ago we saw a man at Out-patients who had been warded with a fractured base, and there was very little doubt he had, after his accident, acquired a gradually-increasing nerve deafness: and I have seen a similar condition in a sailor, who fell from the mast on to his head on the deck, after which he never heard a sound, both auditory nerves having been torn through, though the facial nerves on both sides were intact. The man I first mentioned had no evidence of paralysis, and it was not probable that his auditory nerve was torn through at the time of the accident, but was involved in blood clot, or in the fibrous tissue produced at the seat of the fracture. This lesion has a very definite medico-legal possibility, *i.e.* from the point of view of the Employers' Liability Act, and it does not do to omit to eliminate the possibility of its presence.

Lastly, I have drawn up a list of the different common causes of nerve deafness, and I have tried to arrange them according to their sequence in age. First, let us consider a child six months old who is brought to you with complete deafness, or deafness which you discover to be nerve deafness. The cause can only be a congenital abnormality of some portion of the apparatus. It is one variety of deaf-mutism, and all one need say about it is that the prognosis is hopeless, and the only treatment is for the child, when old enough, to learn lip-reading. Then the child of two years, whom you may find has absolute or a high degree of nerve deafness on one, or more commonly both, sides usually comes with a history like the one I mentioned above of having had brain fever, from which he recovered: this may have been cerebro-spinal meningitis, which as you know in some countries occurs in epidemics, though the cases I have seen have been due to non-tuberculous basal meningitis.

Next would come the child between five and ten years with nerve deafness, and I think you would find a third factor, namely, one of the specific fevers. Everybody knows that the ear often runs after measles and scarlet fever, that is to say, middle ear deafness is common; but you must also realize that all these diseases can act on the internal ear by producing a toxic neuritis of the auditory nerve. You know the toxic neuritis which is present in typhoid; it is also common in influenza, and the prognosis in both these last diseases is usually good. But a similar toxic neuritis occurs in scarlet fever, measles and, perhaps more commonly still, in mumps, and it may be unilateral: when it occurs in mumps it commonly is permanent.

Next, the common cause of nerve deafness near and after puberty is congenital syphilis, and I do not think I have seen a case of nerve deafness between fourteen and twenty-one which was not due to congenital syphilis. The books I have read say the diagnosis of this disease is usually easy. I remember very well a girl who was attending Mr. Purves' out-patients, in whom we were so much interested that she was taken to the Otological Society, where the common consensus of opinion was that she had congenital syphilitic nerve deafness, and the only confirmatory lesion in her case was some choroidal change in one eye. The books point out that involvement of the labyrinth in congenital syphilis occurring at this age commonly follows the stage of interstitial keratitis; and that as the eyes get well the nerve deafness develops, but it is not always so. I suppose we have now four or five cases of congenital syphilitic nerve deafness attending the Ear department, and in them we generally find some evidence of the early attack of iritis, and often some choroidal changes. In one or two there has been gummatous periostitis with necrosis, for instance, of the nasal septum or palate, but only once have

the typical Hutchinson's incisors been present to help in the diagnosis.

These cases have generally extreme deafness, often with vertigo and distressing tinnitus, and sometimes, as in the case I took to the Otological Society, the onset of deafness is absolutely acute, for she lost her hearing in one night after what her mother regarded as a bilious attack. Bear this in mind, for it is not uncommon to see these labyrinthine attacks in congenital syphilis produce sudden complete deafness, and it is these cases which are associated with much giddiness, especially in the early stages; in other forms of the disease the trouble is slow and progressive, giddiness is absent or not much trouble to the patient. In contrasting these two types, it may be that in the former the labyrinth is affected by an acute syphilitic inflammation, and in the more chronic cases a gummatous neuritis has involved the cochlear rather than the vestibular division of the auditory nerve. Unless the patients come under treatment in the first two months after onset of symptoms, probably all treatment for the deafness is hopeless: I must say I have never done any appreciable good: most aurists recommend pilocarpine hypodermically, one-twelfth grain daily gradually increased for some few weeks, and the frequent application of blisters: I think mercury does no good, but iodides sometimes relieve the noises.

At about the same age you must be on the look out for hysterical nerve deafness. I mention it because so many authorities talk of it, but I do not think I have ever seen a case of definite hysterical nerve deafness. If you meet such a case the prognosis is good, but I think it is seldom safe to diagnose hysterical nerve deafness.

In middle life the causes of nerve deafness are a fractured base, labyrinthitis due to working in a noise, secondary labyrinthitis after chronic catarrhal or suppurative middle ear disease, labyrinthitis from chronic nephritis, or in late secondary syphilis and toxic neuritis due to drugs, and I think it is clear in most of the above how to make a diagnosis and what the treatment is. Toxic neuritis has been observed from alcohol, tobacco, lead and drugs, of which the most common are quinine and salicylates, and I would warn you about one or two things in connection with quinine deafness.

One of the best known aural surgeons in London recently read a paper before the Otological Society on quinine deafness, and thought it much more common than formerly, which is perhaps due to the fact that people travel abroad more, and that many people were taking the drug in South Africa in the recent war: his chief object, however, was to point out that the deafness does not, as was usually taught, always clear up, but that the deafness associated sometimes with constant tinnitus may become permanent. With this opinion I entirely agree, and I feel sure that we must all learn to give quinine with great caution, for it is quite clear that these distressing symptoms are not by any means proportionate to the doses taken or the length of time during which it has been used: treatment by hydrobromic acid or bromides is sometimes of great value.

Occupation deafness is often known as boiler-maker's deafness. It is acquired by people who work in a noise. It is only controlled by two obvious things, (1) to cease the occupation, (2) to block the ears with cotton wool while working. Labyrinthitis in acquired syphilis has much the same characters as in the congenital form; it occurs usually as a diffuse labyrinthine infection one or more years after inoculation, though late gummatous invasion of the auditory nerve is sometimes seen. Pilocarpine hypodermically in one-twelfth grain doses daily has many advocates, but I have always found iodides of more value in relieving the noises and stopping the progress of the deafness.

After 50 years of age, hæmorrhagic labyrinthitis, commonly known as Meniere's disease, becomes common, the symptoms are typically acute in onset, with a tendency to fall to the affected side, sudden tinnitus, nausea and vomiting; deafness is noticed gradually increasing after the attack, which is often recurrent, and if both ears are attacked the power of equilibration may be affected. It occurs in two forms: the epileptiform, which is recurrent; and the apoplectiform. Here we have to make a diagnosis from many diseases, such as epilepsy, cerebral hæmorrhage in which the prognosis with regard to life may be grave, and we must bear in mind that in Meniere's disease there are no convulsions, consciousness is not lost, there is no real biliousness, and that nerve deafness is always appreciable, increasing after each attack. The treatment during the attack should be leeching, blisters and bromides internally, and after the attack careful diet with little or no alcohol, avoidance of excessive business or professional labour, and regular, gentle exercise and a regular yearly holiday.

In old age the senile change in the auditory perceptive mechanism which is usually demonstrable after fifty becomes more marked and is sometimes extreme. Though direct treatment

is unavailing, it is well to remember that treatment, when necessary to the external or middle ear of such a patient often helps to appreciably augment the defective hearing and is much appreciated.

Finally, bear in mind that speaking tubes, trumpets and artificial drums are absolutely useless to the subjects of nerve deafness, for the obvious reason that sound conduction is in them usually perfect.

A Case of Malignant Endocarditis treated with Antistreptococcic Serum. Recovery after 4 months.

George P., æt. 51. Retired police constable.

Family history.—Father, æt. 73, and mother, æt. 80, died from senile decay. Only one brother, who has had two attacks of rheumatic fever, and one sister, who enjoys good health.

Previous history.—At 18 years of age came to London and joined the Metropolitan police. After five years' service he had an attack of acute rheumatism. He had a second attack five years after this, a third in another five years, and a fourth again five years after. Following on the last attack he was invalided out of the force. He never heard at any time that he had anything wrong with his heart. Except for the attacks of rheumatism he has enjoyed good health.

Present illness.—He came to see me on October 17th, 1903. He then complained of headache and pains in his limbs. His temperature was then 101·4° and pulse 100. The tongue was furred. Urine, sp. gr. 1018, neutral, with slight trace of albumen. I thought he was suffering from influenza, so I sent him home to bed. I could find nothing amiss except an apical systolic murmur, which I thought had been caused by one of his rheumatic attacks. There was really nothing to be made out of the case for a long time. He complained at times of slight pain and uneasiness over the cardiac and gastric regions.

After giving up influenza as a diagnosis, I fell back on enteric fever, though there was no diarrhœa and no distinct abdominal signs. Later on I suspected tuberculosis, and last of all malignant endocarditis. On November 19th he was seen by a neighbouring practitioner who thought he had pneumonia, but of this there was no evidence. On December 12th he was seen by another medical man who, after a careful examination, declined to pronounce any opinion on the case.

On December 3rd I wrote an account of the case to Dr. Shaw, and sent him a copy of the man's chart up to that time. He suggested malignant endocarditis or possibly tuberculosis as the cause, and that a trial might be given to antistreptococcic serum. This I proposed to my patient, and he was so averse to the idea that I did not press it.

During the whole course of the illness the temperature ranged from 100° to 102·6°, occasionally dropping to normal of a morning, but invariably rising again in the evening. The curve was a very erratic one. He had absolutely no symptoms at all except the persistently furred tongue which after a time became dry and brown. He ate his food well all through, and his bowels were kept acting pretty regularly by the aid of calomel. The pulse kept at from 90 to 100, though on two occasions I counted 120 beats. The spleen was not noticeably enlarged.

On January 26th, 1904, he complained of night sweats, and after further pressing the point, and as he was evidently going downhill, he consented to my trying the serum on him. Accordingly, on January 29th, I injected 10 c.c. of antistreptococcic serum (Burroughs & Welcome's) between the scapulæ. There appeared to be no reaction, and no change.

On February 1st I gave him a second injection of 10 c.c., and on February 7th I injected 10 c.c. more. On February 14th a purpuric patch came out on the right wrist. On February 16th he had a rigor and complained much of pain in his joints, and thought he was going to have another attack of acute rheumatism.

On February 17th, trismus set in quite suddenly, and he was only able to open his jaws about half an inch. Things began to look serious, and I almost lost hope; but from that time amendment began.

On February 20th the temperature, for the first time since the commencement of the illness, fell to normal at night, and normal it has remained ever since. The man is now up and about, and is slowly regaining his strength.

R. A.

Blue Urine.

My partner and I have recently had a case of this interesting condition, and with the help of the article on "Blue Urine" by Dr. Beddard, which appeared in the LVI. Vol. of Guy's Hospital Reports, p. 127, a correct diagnosis of the pigment causing it was arrived at; reference to the above paper will elucidate the following notes:—

W. J., male, æt. 50, came up to the surgery complaining that he first noticed his urine was "blue" on the night of March 6th, and has continued so for several days since, being somewhat darker in colour than at first. He is a labourer in some large steel works, and has taken neither medicines, nor pills of any kind lately to his knowledge; has had nothing to do with paints, dyes, or pigments, and has sucked no dyed material; and he alone of his family has been so affected.

He passed a specimen of urine having the following characters:—It was of a "peacock blue" colour and

distinctly acid in reaction, and with strong HNO_3 gave a faint ring of albumen; on being placed in a bottle and corked, however, the colour did not disappear, even though left for several days thus. The following tests being applied clearly proved the pigment present in the urine to be methylene blue. For a control experiment one of us took a pill containing grs. ij. of methylene blue, and passed urine the following day exactly the same colour (*i.e.* peacock blue) and this specimen, on being subjected to the same tests as the original, reacted similarily:—

	Original specimen.	Control urine.
Spectroscopic analysis—		
Gave the characteristic dark narrow band at extreme red end of spectrum		"
Chemical tests—		
1. Reaction, acid		"
2. On shaking with chloroform—pigment extracted		"
3. On shaking with ether—no pigment extracted		"
4. Blue colour did not disappear in either, when urines were corked in bottle for two days. (This was probably due to there being no active growth of bacteria in the urines, and consequent lack of supply of oxygen, for converting the methylene blue into a colourless compound.)		
5. On heating with strong HCl—turns red (instead of colour disappearing and returning on shaking with air)		"
6. On heating with strong HNO_3—turns a dark green (colour should remain unaltered)		"

These two latter tests were probably complicated by the presence of two chromogens, which, on heating with mineral acids turned into *urorosein* and *indigo red*, probably both were present.

Conclusions.—That the pigment was due to the methylene blue (which cannot be manufactured in the body) introduced from some unknown source; and not to indigo blue which is either absorbed as such, or derived from proteid decomposition in the alimentary tract.

111, Great Mersey Street, Liverpool. E. I. CLAXTON.

Note.—Since writing the above I have on careful inquiry at the works where patient is employed, found out from his foreman, that some large steel dies were lying in a corner of the works, close to some "pools of blue liquid" (What liquid? He does not know!) and that the patient was engaged in marking and shifting some of these, before he sat down to eat his dinner without washing his hands. This seems to be the probable explanation of the introduction of the pigment into his system.

Nursing News.

Matron's Office.

On February 25th, Nurse Morley, Head Nurse in Naaman, was transferred to the Theatre, and Probationer Woodward was appointed to succeed her as Head Nurse.

On March 8th, Nurse Melia left the Hospital on completion of her three years' training, and Probationer B. Cheesman was appointed to succeed her as Head Nurse in Lydia ward.

On March 10th, Nurse Hayward left the Hospital on completion of her three years' training, and Probationer Bois was appointed to succeed her as Head Nurse in Dorcas ward.

On March 19th, Nurse Essex left the Hospital on completion of her three years' training to take up her duties on the Private Nursing Staff. Probationer Slack has been appointed to succeed her as Head Nurse in Cornelius.

On April 6th, Nurse Garnet was transferred to the Out-patient Department, and Nurse Carr-Hill to Miriam ward.

The following Nurses and Probationers have been successful in passing the Examination in Practical Pharmacy and Dispensing held on March 24th, 1904:—F. Evans (1), L. Bonser (2), E. Yeates (3), Foskett, Lear, G. Harvey, L. Scott, Coward, Bois, du Sautoy, Leather, Anderton, Coulson, Blott, Waterman, Fox, Jickling, Rigby, Parr, Hill, Farrar, Dickenson, G. Hughes, Elwin, Powell, M. Harvey, Fraser, Tippetts, Mackay, M. Adams, Pagan, Millard, Clutton, Waldron, Jackson, H. Whitefoord, Moore, Maile, Cadell, Hedgecock, Lulham, Woods, Neale, Cannell, Dawson, Leverton, Sheldon, Windridge, Danson, Wetherell, Herd, Belcher, M. Stanley Adams, Ellis, B. Cheesman, Carr-Hill, Humphery, Gration, Spicer, Bromwich, Bevan, Bingham, E. M. Cheesman, Douglas, Holman, Oliver, Leonie, Slack.

A Nursing Guide.

A most useful little book is the second issue of the "Nursing Guide," which has just been published for 1904.

It is a perfect mine of information for all interested in nursing, and those desirous of entering the nursing profession will find everything made very clear for them.

The book contains a Register of Nurses trained at Guy's, and for this alone should prove a help to all old Guy's men, to whom we heartily recommend it.

The price is one shilling and sixpence and may be obtained from Messrs. Ash & Co., Ltd., 42, Southwark Street, S.E., or from Mr. Grattan, in the Borough.

In Lighter Vein.

POT-POURRI.

Scene.—*The Pathological Museum.*

Characters:—

Eminent Surgeon—*Just about to make his exit.*

Eminent Assist. Physician—*Teaching a private pupil, on first gallery.*

A Senior Man—*Audibly learning Pharmacy.*

Four Junior Men—*Making heroic endeavours to learn Anatomy with the aid of one sphenoid bone, and two "Grays."*

Myself—*Sitting, with easy grace, upon the edge of a table, and trying to write a "Lighter Vein" on paper, borrowed (without permission) of the Curator.*

N.B.—Underneath the clock is a board bearing the legend "silence," but that is only regarded as an ornament!

Eminent Surgeon: Now, if only I could persuade you fellows to read less Physiology, and more of "Sidney Smith," I should, perhaps, be able to make something out of you.

[*Smiling exit.*

Eminent Assist. Physician: Of course I don't pretend to know any Anatomy now. The subject is alright in its way; but it is dead, my dear fellow, dead as a door-nail. Where men make a mistake is in not reading their Physiology. This is why all Clinical people are always wrong. If you want to understand Medicine properly, you should try—er, that is to say, you ought—well, I mean, it would be a very good idea to remember that—

Senior Man: "A very good dose for barter, is jalap, ginger and cream of tartar." I wish I could remember these things better; now, what are the preparations of sulphur?

[*Rapidly becomes incoherent.*

Eminent Assist. Physician: The great point about these lesions of the cord, is this—

First Junior Man: Nobody can learn the wretched stuff, if you always keep the bone to yourself, B. Pass it down this way, and let me have a look at it. Ah yes! The foramen ovale transmits—

Senior Man: The trohiscus and the liquid extract. It seems to me, that the only reliable tip for these things, is—

Eminent Assist. Physician: A knowledge of the minutiæ of the Spinal Cord, from the histological point of view. You know that the most important tract to be met with in the dorsal region, is known as—

First Junior Man: The inferior maxillary division of the fifth nerve. Is it a physical impossibility for you to give me a fair share of the book, B.? Because, if so, the only way for me to learn Anatomy, will be to—

Senior Man: Learn the beastly stuff by heart, and make your own tips. After all, even a parrot could say—

Eminent Assist. Physician: The difficulty is to maintain an efficient—though not pedantic—differentiation between the pathological and physiological conditions. A difficulty which is increased by the necessity which arises, to retain coherence, whilst never losing the direct logical sequence. You will easily follow this, and your opinion will, in all probability, coincide with mine. Without, in any way, wishing to appear egotistical, I think I may safely lay claim—that is, I can honestly say, that—

Second Junior Man: Of all the unutterable rot, I think this is the most unspeakable! Who cares about the shape of the lingula? The only shape which ever interested me, was—

Senior Man: The octahedral prisms of oxalic acid.

Freshman (showing a "cousin" round the Hospital): Yes, this is the museum. This is where they keep the wax models. What? Oh! all sorts of diseases, you know. There really is not time to explain. Yes, all these men are students—Oh no,—not that one! He is the boy-of-all-work. The "things" in bottles are not wax. They are real—preserved in spirit, you know.

The "Cousin": Oh, what a horrid place! Please take me away. [*Affectionate exit.*

Myself: D——!!!

THE WANDERING JEW.

Notes from Skin Outers.

Seborrhoea.

A scurfy head is hardly likely to be taken as a subject for a thesis or prize essay, nevertheless the successful treatment of a case may mean much to the practitioner and his patient.

Seborrhœa capitis may occur in two forms—(1) *S. sicca* or dry scurf, or (2) *S. oleosa*, where the scalp is quite oily.

The skin often has a rather characteristic salmon-pink colour.

In infants the disease causes the formation of dirty yellow greasy masses, thickest about the anterior fontanelle (*S. cerea* or *waxy S.*). In adults the dry form is the most frequent cause of premature baldness.

Seborrhœa is most commonly ascribed to over-activity of the sebaceous glands, which, according to Sabouraud, is dependent upon the action of a specific bacillus; although this has not been proved by other observers, the course taken by the disease, especially in spreading downwards from the scalp to other parts, and the results of applying mild germicides, points to a bactericidal origin being the probable one.

Unna considered that the sweat-glands also might be involved.

Speaking broadly, seborrhœa always begins on the scalp, but may spread to the face, where the oily form is the most common, it may affect especially the whisker-region or about the nose.

Seborrhœa corporis, which almost always occurs in conjunction with S. capitis, is prone to attack the middle line, both back and front, of the upper part of the trunk—thus the skin over the sternum and between the shoulder-blades.

The salmon-pink greasy patches are apt to clear up in the centre and assume a ring-like form.

Sir Cooper Perry points out that it may, however, occur in three varieties:—

1. The characteristic well-defined circular patches just mentioned.

2. A papular form, where the edges are not so well defined, and which may be confused with eczema.

3. A form in which the scale-formation may resemble psoriasis, but in seborrhœa the scales are greasy and can be dissolved in ether.

A popular name for S. corporis is "flannel-rash," as it occurs chiefly in those who wear thick, coarse underclothing (M. Morris).

If neglected, seborrhœa may give rise to an eczematous condition—*seborrhœic dermatitis;* and in old subjects flat, pigmented warts may form *seborrhœic warts*, or *senile warts* as they are sometimes called.

The only subjective symptom of seborrhœa is slight itching.

In a doubtful case of seborrhœa elsewhere, the diagnosis can almost always be clinched by an examination of the scalp, which is practically certain to be affected.

As regards treatment, the following applications may be recommended.

For seborrhœa capitis—

1.	Acid. Acetic	...	℥ss.
	Resorcin	...	ʒij.
	Eau de Cologne ...	...	ʒij.
	Glycerine	...	℥ss.
	Aq. Rosæ to		℥viij.

To use as a daily wash.

This is one of R. Crocker's prescriptions, and the writer found it extremely efficacious in his own case. It must be well rubbed in.

In obstinate cases the same authority recommends—

2.	Ung. Hyd. Nit. ...	...	ʒij.
	Ol. Cadini	...	ʒj.
	Ol. Olivæ	...	ʒij.
	Lanoline	...	ʒiv.

To be rubbed in at night.

Sir Cooper Perry has prescribed for scurf—

3.	Quin. Hydrochloridi	...	grs. v.
	Spts. Rosmarini ...	...	ʒiij.
	Aq. ad		℥j.

Or again—

4.	Hyd. Perchlor. ...	...	gr. ½
	Ammon. Chlor. ...	...	gr. 1
	Spts. Rosmarini ...	..	ʒiij.
	Aq. ad		℥j.

And for seborrhœa corporis, an ointment containing—

5.	Resorcin	...	grs. 5
	Precip. Sulph. ...	...	grs. 5
	Ung. Paraffin ...	...	ʒj.

Malcolm Morris recommends the following lotion—

6.	Precipitated Sulphur	...	℥ss. to ʒj.
	Distilled Water ...	...	℥viij.

To be rubbed in with a little brush at bed-time.

Besides the local treatment it would be advisable to treat any concomitant gastro-intestinal, or other constitutional disorder.

Change of Address.

Dr. C. E. Carpmael, from Dulwich Village to 17, Half Moon Lane, Herne Hill, S.E.

Dr. J. B. Copland, from Guy's Hospital to Banks Terrace, Sheerness.

Mr. W. E. Derriman, L.D.S., from Guy's Hospital to Cerne Abbas, Dorset.

Dr. F. W. Fawssett, from Guy's Hospital to 228, Fore Street, Upper Edmonton, N.

Dr. G. Moir, from Hertford Infirmary to Stoneleigh, Titchfield, Fareham.

Dr. H. McD. Parrot, from Grove Vale, East Dulwich, to 29, South Side, Clapham Common, S.W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Case for Diagnosis.

W. J. T., æt 37, admitted February 21st, for epigastric pain and dyspnœa. He was a very obese man, a confectioner by trade, and moderate in use of alcohol. There had been some œdema of the legs, but this had subsided before admission. There was a history of rheumatic fever when 11 years of age, and of gonorrhœa 20 years ago. Three months before admission, patient, who was a volunteer, was suddenly attacked with shortness of breath and epigastric pain, whilst on a march, and had to fall out. The pain passed off, but would always recur on any extra exertion. Three weeks before admission, he was treated by a doctor for indigestion; at this time he was subject to attacks of vomiting after taking food, but this symptom lasted only a week. Having further attacks of pain, he was advised to come into the Hospital. On examination, nothing abnormal found in the respiratory system—a reduplicated second sound at the apex—slight tenderness in the epigastrium on pressure. The urine contained 5·5 parts per 1,000 of albumen. On March 4th, a tumour was felt in the epigastrium, having a semi-circular outline, suggestive of enlarged left lobe of the liver. Patient had a good deal of vomiting, but was troubled chiefly with insomnia, his appetite was very bad and he suffered from intense thirst. On March 15th, after pain in the calf muscles, the feet and legs became very œdematous, the œdema gradually spreading upwards. On March 18th, signs of fluid having appeared in the right chest, it was aspirated and 55 ounces withdrawn, and patient was less dyspnœic. On March 23rd, œdema became marked in the abdominal wall, chiefly on the right side and right flank, extending to level of last rib, the swelling had a definite edge, and was slightly red. At the same time a purpuric rash appeared, which gradually spread over the legs, arms and chest. On March 30th. patient was seized with an attack of syncope, with much cyanosis and dyspnœa, and died in a few minutes.

During the illness the temperature never rose above 99°, except on one occasion when it went up to 102° for four hours. Albumen was always present in the urine, and averaged four parts per thousand.

Papers by Guy's Men.

A Case of Scurvy in an Infant Fed on Municipal "Humanized" Sterilized Milk. By Henry Ashby, M.D., F.R.C.P.—*British Medical Journal*, February 27th.

The Etiology of Scurvy. By Myers Coplans, M.B. Lond.—*The Lancet*, March 5th.

Some Notes on the Urine in Beri-Beri. By Herbert E. Durham, M.B., B.C., F.R.C.S.—*British Medical Journal*, February 27th.

On the Distribution of Bacillus Coli in Nature. Preliminary Note. By J. W. H. Eyre, M.D. Durh., F.R.S.—*The Lancet*, March 5th.

Pass List.

University of Oxford, March, 1904.

DOCTOR OF MEDICINE.

Herbert S. French.

University of Cambridge, March, 1904.

BACHELOR OF MEDICINE.

C. M. Murray.

Royal College of Surgeons of Edinburgh, March, 1904.

ADMITTED TO THE FELLOWSHIP.

A. D. E. Kennard.

Appointments.

Civil.

Colclough, W. Frank, M.D., B.C. Cantab., has been appointed Medical Officer to Out-patients, Yeatman Hospital, Sherborne.

Cross, Francis G., F.R.C.S., has been appointed Divisional Surgeon for V Division, Metropolitan Police, Kingston-on-Thames and Surbiton.

Hancock, W. Ilbert, F.R.C S., has been appointed Assistant Surgeon to the Central London Ophthalmic Hospital.

Milward, W. C., M.R.C.S., L.R.C.P. Lond., has been appointed District Medical Officer of the Cardiff Union.

Richmond, G. E., M.D., B.S., B.Sc. Lond., D.P.H. Camb., has been appointed Demonstrator of Hygiene and Public Health at University College, London.

Telling, W. H. Maxwell, M.D., B.S., M.R.C.P., has been appointed Assistant Physician to Hospital for Women and Children, Leeds.

Turner, Philip, M.S. Lond., F.R.C.S., has been appointed Assistant Surgeon to the Belgrave Hospital for Children, Clapham Road.

Naval and Military.

Fleet Surgeon E. R. D. Fasken, R.N., has been appointed to the *Æolus*.

Staff Surgeon E. P. Mourilyan, M.B., is promoted to be Fleet Surgeon. He was with Captain Bearcroft's Naval Brigade from Modder River to Kroonstad in 1900.

Surgeon Captain A. E. Larking, 1st Volunteer Battalion the Buffs (East Kent Regiment) resigns his commission.

J. K. Clark, L.D.S.R.C.S. Eng., and C. W. Randall, L.D.S.R.C.S. Eng., have been appointed Dental Surgeons to the troops from April 1st.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Medical Service of the Navy.

Dear Sir,—You have several times asked me for a letter on the above subject, and this must form my excuse for this letter.

It is generally acknowledged by all those at all conversant with matter, that naval medical officers have reasonable grounds for many serious grievances, and consequent discontent, and no one knows this better than myself, for I have been through the mill, and therefore have the advantage of personal experience.

It is quite certain that so long as their lordships can attract a respectable number of candidates to their entrance examinations—quantity and not quality being the criterion—so long will reform be put off, unless, indeed, a naval war should be entered upon (which Heaven forbid!), when necessity will displace expediency, and suddenly black will be called black, and white, white; we shall dispense with grey then, and with it a number of cobwebby institutions which are now employed to hoodwink the public.

I say hoodwink and I mean hoodwink (or bamboozle, if you prefer it). I will take what I believe to be the latest printed information on the subject. In the Supplement to the *British Medical Journal*, dated December 5th, 1903, we find an instructive table "shewing the extent of competition for each service" (*i.e.*, Navy, Indian and Army), the results of recent examinations. Under the heading Royal Naval Medical Service we read—

No. of Examinations	...	1
No. of Vacancies ...	...	15
No. of Candidates ...	...	22

Amount of competition—3 candidates for every 2 posts.

From a consideration of the above every sane person would conclude that not only is the Naval Medical Service complete as regards establishment, but that there are plenty of men left over who are clamouring for admittance. But is this so?

Turning again to the *British Medical Journal* for inspiration, we find stated in an editorial, dated March 19th, 1904, "The total establishment is 544 officers, and the Navy List for March shows that the number actually in the service is *only* 22 below that figure."

The italics are mine. Why, I ask, *only?* and with three competitors for every two vacancies!

Do, for goodness sake, let us be honest and play the game by our own commonsense! The above only shows that the competitors for commissions are of such a low standard that only two out of every three can obtain more than the lowest minimum of marks to enable the examiners to recommend them for commissions.

Under the circumstances one is inclined to thank God that one is not consigned to the tender mercies of ——— well, let me leave the sentence unfinished. I will put it in this way. If I had a son or other relative in the navy, and learnt that he was ill, I should wonder what sort of medical care he was committed to by chance. It might, I know, be good; on the other hand, it might be bad, or merely indifferent.

The worst of it all in the service is that the functions of the consultant and specialist in civil life are usurped by a class of man who simply arrives at his exalted position by the right of age and seniority.

I am proud to think that there are many able men in the senior ranks of my late service, but there are, alas, many others; and chance alone—aided often by war promotion—is left to decide whether a critical case falls into competent or incompetent hands.

I feel it my duty now that I am free to do so, to write and talk about these things. The *British Medical Journal* speaks of "the iron discipline of the navy" as tending to prevent reform coming from within. This has long been recognised. As long as I was in the service I held myself honourably bound by this discipline, it is different now that I have left the navy.

I am not writing for self-advertisement, or from any snobbish desire to be called Commander, Captain or Admiral, but I would like to see a worthy profession put into a position where self-respect, moderate comfort, and a modest competence were possible to those who deserved it.

I had hoped to "work the oracle" through my own cloth, and therefore appealed to the *British Medical Journal*, but the treatment I have received can hardly be called encouraging. For want of any obvious cause for this I can only conclude that the editor of the *British Medical Journal* imagines I am doing a little cheap advertising. I had thought that signed letters would carry more weight, but I am possibly wrong, and although I by no means intend to relinquish the "unequal contest," this is the last letter on the subject to which I propose to sign my own name.

I have said and I say again—

1. That for medical questions the Medical Director General must be made a Lord of the Admiralty.
2. Medical surveys must be under the presidency of a medical officer—not an executive.
3. The question of war promotion must be reconsidered.
4. Specialism must be instituted.

I have confided in the *British Medical Journal*, and said if anything is to be done, a spade must be fearlessly called a spade. That august journal has, however, taken up a position which, if called by the authorities diplomatic, must at least by their readers be considered unconvincing.

There are two ways in which a perfectly just cause can be lost: one is over-zeal, the other is the opposite. The editor of the *British Medical Journal* has accused me of the former; I will have the temerity to accuse him of the latter. If a subject is important enough for a lengthy editorial, it is important enough to be immediately proceeded with and dealt with. There must be material

enough to work on, or else a responsible journal is not justified in taking up a tangible position.

I would venture to remind the editor of the *British Medical Journal* that if many cases are lost by "over-coloured pictures," more are lost by indecision and half-heartedness. The editorial, "Mark I.," appeared on March 19th, 1904, and the matter has been allowed to apse since. If a thing is worth doing at all, it is worth doing well; at least that is the opinion of most capable people.—Yours, etc.,

GERALD SICHEL.

"The Labourer is worthy of his hire."

Dear Sir,—I take advantage of your well-known courtesy in asking you to kindly insert this letter. I should not presume to occupy your valuable space were it not for the fact that my complaint is an universal and, I think, a just one. It is generally acknowledged that all surgeons' dressers have to work reasonably hard throughout the term of their appointment.

During the "take-in" week their labours are greatly increased, and the dressers of the week have to place the whole of their time at the disposal of the hospital. In return, they receive their board (or part of it!) and sleeping accommodation. Until recently they had a room each, but now, owing to the unfortunate elevation of the dressers' sitting-room, they are obliged to share a room. The great inconvenience of this plan is obvious. Whenever it becomes necessary to call one of them, his colleague is, of necessity, also awakened; and, as one dresser is almost invariably required in the course of the night, it is quite clear that neither of them will be able to get a sound night's rest during his week of office!

Now, when one considers that the dresser for the week has most trying and arduous duties to perform throughout the day, it is surely only fair that he should have a chance of getting an undisturbed rest, at least once in every forty-eight hours. Under the old system this was possible, but in the present state of things it is not.

There is yet another objection which has, I fancy, some claim to consideration. It is not always possible to choose one's best friend as a colleague. Consequently, it is easy to find oneself compelled to an intercourse of the most intimate nature with an uncongenial companion. To have daily association with such an one is very annoying, but formerly one could always count upon privacy at night. Under the present system, even this small privilege is denied us!

I am surprised that nobody has raised this question before in your columns, but I suppose it is only part of the general tendency to let things slide.

I think that when we are doing the work of the hospital we should be properly provided for, and I feel sure that the grievance has only to be mentioned in order to be redressed.—I am, sir, yours truly,

A FUTURE DRESSER.

Antiquarian Department of New Museum.

Dear Sir,—I was glad to see in a recent number of the Gazette a suggestion that a section of the new museum should be devoted to the archæology and history of medicine and surgery.

In taking leave of Guy's after fifteen years' work, I received a very kind letter from the Staff in which a wish was expressed that I might still keep in touch with the hospital. This, with the encouragement of the Staff, I hope to do in connection with the above object, and in order to make a start I shall be glad to give a small collection of ancient surgical instruments which I have got together during the last twenty years. If those who possess, or who can get possession of, any old and interesting instruments, more especially any connected with the history of Guy's, and who may be willing to give them to the museum, will send them to me with *a note as to their origin, and where possible with a date*, I shall be very pleased to receive and later on to arrange them in proper order in our new museum.

May I instance a few points which would work out well. I shall be able to put in order a series of trephining instruments which covers the Georgian period, but to complete this one wants the cross handled iron trephine of Wiseman and the whole of the "stock and bit" forms of the trepan.

Again, let us take amputation instruments, a series of knives might well start with the bill-hook pattern of Tudor times and end with the nearly straight, round-ended, circular amputation knife which is still occasionally used. The order would have to include a sub-order of straight knives such as the two feet flap-knife of Liston, the varying forms of the double-edged or Cattlin knife, and even that large scalpel which a distinguished provincial surgeon said was all that was required to remove a thigh. Or we might go to bladder surgery. A nice row of silver catheters with the artistic adornments of our forefathers which made the instrument look like a short caduceus—such a one I have seen in actual use, which dated back to the time of Queen Anne—would add grace to the show case. Or the older instruments of lithotomy—the double dilator, the blunt and cutting gorgets, and so on.

I might go on making a list as long as a modern instrument catalogue, but you see, sir, what I want, viz., materials to make a museum department at Guy's as good as, or rather, I should hope, better than that in any other hospital museum in London. So I say to the many who own allegiance to the old place, hunt up all you can while there is yet time, for antisepticism with its steam sterilizer has practically abolished the old order of surgery and its instruments, and the tools of our forefathers are even now being cast on to the scrap-heap whence in a few short years it will be in vain to try and retrieve them.—Believe me, yours truly,

F. WILLIAM COCK, M.D., F.S.A.

1, Porchester Houses,
London, W.

Notices.

REGULATIONS FOR THE EXAMINATION IN TROPICAL MEDICINE AND HYGIENE CONDUCTED BY THE STATE MEDICINE SYNDICATE OF THE UNIVERSITY OF CAMBRIDGE.

An Examination in Tropical Medicine and Hygiene will be held in Cambridge during the year 1904. The Examination will begin on 9th August, and extend over three days.

Any person whose name is on the *Medical Register* is admissible as a Candidate to this Examination, provided—

(I.) That a period of not less than twelve months have elapsed between his attainment of a registrable qualification and his admission to the Examination;

(II.) That he produce evidence, satisfactory to the Syndicate, that he has diligently studied Pathology (including parasitology and bacteriology) in relation to Tropical Diseases, Clinical Medicine and Surgery at a Hospital for Tropical Diseases, and Hygiene and Methods of Sanitation applicable to Tropical Climates.

*** As evidence of study and attainments, a Candidate may present to the Syndicate (1) any dissertation, memoir, or other record of work carried out by himself on a subject connected with Tropical Medicine or Hygiene, (2) any Certificate or Diploma in Public Health or Sanitary Science he may have obtained from a recognised Examining Body. Such evidence will be considered by the Syndicate in determining whether he is qualified for admission to the Examination, and by the Examiners in determining whether, if admitted, he shall be included in the list of successful Candidates.

The Examination will have reference to the nature, incidence, prevention, and treatment of the epidemic and other diseases prevalent in Tropical Countries. It will comprise the following subjects;

1. The methods of pathological and bacteriological investigation. The examination of the blood. The characters, diagnosis, and life-history of animal and vegetable parasites. The examination, chemical and microscopic, of poisonous or contaminated foods and waters.

2. The origin, pathology, propagation, distribution, prevention, symptoms, diagnosis, and treatment of the epidemic, endemic, and other diseases of Tropical climates, including—Malaria; Blackwater Fever; Trypanosomiasis; Relapsing Fever; Dengue; Yellow Fever; Plague; Tetanus; Beriberi; Dysentery and Hepatic Abscess, Cholera, Enteric Fever, Malta Fever, and Specific Diarrhœal affections of the Tropics; Diseases due to Cestode and other worms; Filariasis; Bilharzial disease; Specific Boils, Sores, and other Cutaneous affections; Mycetoma; Ophthalmic affections of the Tropics; affections caused by poisonous Plants and Animals, and by poisoned weapons; Sunstroke.

3. The general effects on health in the Tropics of seasons and climate, soil, water and food. Personal hygiene, acclimatisation. Principles of general hygiene, with special reference to food and water-supplies, sites, dwellings, drainage and the disposal of refuse. The Sanitation of native quarters, camps, plantations, factories, hospitals, asylums, jails, pilgrim and coolie ships. Principles and methods of disinfection.

The Examination will be partly in writing, partly oral, and partly practical and clinical. The clinical part will be conducted at a hospital for Tropical Diseases, at which cases will be submitted for diagnosis and comment.

Every Candidate will be required to pay a fee of six guineas before admission or re-admission to the Examination. A Candidate, who after being approved for admission fails to present himself at the Examination, will not have the fee returned, but will be entitled to present himself without further fee on *one* subsequent occasion.

Every Candidate who passes the Examination to the satisfaction of the Examiners will receive from the University a Diploma testifying to his knowledge and skill in Tropical Medicine and Hygiene.

All applications for information respecting the Examination should be addressed to *Mr. G. H. F. Nuttall*, Pathological Laboratory, Cambridge.

Candidates who desire to present themselves for the Examination must send in their applications on forms supplied for the purpose, and transmit them, together with the required evidence of study, and the fee of six guineas, to "The Registrary of the University, Registry, Cambridge," not later than July 22nd. Cheques should be crossed "Barclay & Co., Ltd."

Cambridge,
13th February, 1904.

Papers by Guy's Men.

Remarks upon Temperature. By M. S. Pembrey, M.A., M.D.—*British Medical Journal*, February 27th.

Progress of Medicine—Henoch's Purpura. By Theodore Fisher, M.D. Lond., M.R.C.P.—*The Bristol Medico-Chirurgical Journal* for March.

Two Cases of "Corset Cancer," with remarks on the Origin and Spread of Cancer. By R. Clement Lucas, M.B., B.S. Lond., F.R.C.S. Eng.—*The Lancet*, April 2nd.

A Case of Sloughing of the Central Part of a Uterine Fibro-myoma shortly after delivery. By John D. Malcolm, F.R.C.S. Edin.—*Ibid.*

Abdominal Surgery, Retrospective and Prospective: Based on Fourteen Years' Personal Experience in the wards of the Victoria Infirmary, Glasgow. By A. E. Maylard, B.S., M.B. Lond.—*The Glasgow Medical Journal* for April.

Reviews.

The price of books submitted for review should in every case be stated.

Manual of Pathology. By Joseph Coats, M.D. (Longmans, Green & Co.) 28s.

The edition in hand is the fifth, and it is, we are convinced, not by any means the last. Although, unhappily, the genius of Dr. Coats no longer operates in the world of science, it has an excellent substitute in the careful painstaking method of Dr. Sutherland, who is the present compiler of the work.

Since Dr. Sutherland has taken in hand this deservedly popular volume, there has been a distinct increase in its size, number of illustrations, and good qualities.

Dr. Sutherland gives a very good account of the pathology of bone diseases, aneurysms, and brain diseases in particular. His subdivision of gastric ulcers appears to us to be lacking in that scientific vein which characterises the rest of the book. It reminds us of a physician's writings on surgical subjects.

The general style and "get up" of the book also calls for praise, the cover is neat and serviceable, the print excellent, and the illustrations all that could be desired. We can only wish it the success it has already enjoyed. It has, as especial merits, conciseness, lucidity, exactness and fulness, without the usual accompaniment of tediousness.

Its faults are few, and we think trivial. In many of the chapters are omitted one or two conditions, which, though uncommon, would perhaps have been better mentioned, such for instance as primary chancre in dealing with tongue lesions, and the superficial congestion, short of extensive hæmorrhage, seen in the brains of general paralytics, both of which are undisputed conditions.

Sterilisation of Urethral Instruments. By H. T. Herring, M.B., B.S., Durham. (H. K. Lewis). pp. 175, price not stated.

Apparently this book is written to inform medical men, in order that they may pass the information on to their patients. We were at first in doubt whether it was not intended for the patients, as the tone is didactic, presupposes little intelligence on the part of the reader, and detail and trivialities become extremely monotonous.

The chapters on anatomy of urethra and bladder, and on diseases of the same, are in a vein that one is accustomed to associate with a St. John's Ambulance Class.

The author devotes a chapter to his own inventions for sterilising catheters, etc., which does not appear to be in any way superior to the ordinary methods.

Atlas of Human Anatomy. By Carl Toldt, M.D. Part III., Myology. (Rebman, Ltd.) Price 8s. 6d. net.

This, the third part, containing diagrams and drawings of muscles, maintains the same high standard which we had occasion to note in the previous volumes. The muscles are all coloured, and their relations to one another, to joints and to bones clearly displayed. This work is the nearest approach to the actual dissections which it has been our fortune to encounter, and there can be no doubt of its value in conjunction with the text book. Appended are diagrams on the anatomy of hernia in which clearness and accuracy are again successfully combined.

A Manual of General Pathology. By Sidney Martin, M.D., F.R.C.P. (London: John Murray.) pp. 494, 15s. net.

For some time there has been a real need of a book of general pathology of a size suitable for students and yet sufficiently full in matter. We think the present volume eminently suited to fill the void. A feature of the book is the amount of space taken up on infection and immunity, probably due to tendency of the age towards the bacteriological laboratory on all occasions; however, the matter is up to date and concise, the illustrations of immunity are simple, clear and highly diagrammatic. The chapters on blood embrace all the latest on hæmatology, and is further enhanced by coloured illustrations of the blood in health and disease—those on leukæmia and lymphæmia are the best we remember to have seen in a text book. This book, well bound and well arranged as it is, is heartily to be commended.

Dispensing made easy. By Wm. G. Sutherland, M.B. (John Wright, Bristol). pp. 102.

This little work is full of hints to general practitioners on economy of time, labour and money in their dispensaries.

In the second part is a list of formulæ, compiled from various sources with each component, and its proportion detailed.

The book, of pocket size, will be found quite a useful addition to private dispensaries.

Aids to Surgery. By Joseph Cunning, M.B., B.S., F.R.C.S. (London: Ballière, Tindall & Cox.) 384 pp. 4s. 6d.

This, a small pocket manual, intended for students preparing for their final examinations, is practically Rose & Carless' Manual of Surgery abridged with the plates and diagrams omitted.

There are a good many men who find cramming essential to their success in examinations, for these the book will be found exceedingly useful, at the same time obviating the difficulty and fatigue of "abstracting" the larger surgery book for themselves.

Throughout the arrangement of Rose & Carless' Manual is closely adhered to, and nothing essential is omitted.

Nauheim Treatment of Chronic Disease of Heart. By L. Thorne Thorne, M.D. (Balliére, Tindall & Cox). pp. 53, price 2s. 6d.

The author states at the beginning that he has written this little book with a view to enabling the practitioner

with no previous experience to administer the treatment, even in the home of the patient.

No attempt is made to discuss the theories of treatment, and no account is given of the Scholt system of exercises, which the author considers incapable of being learnt from books, and which, as part of the treatment he seems to regard as of minor importance.

The book contains, besides an outline of the author's treatment, a chapter upon "cases suitable," and concludes with a record of several cases treated, illustrated with sphymographic tracings, which, if reliable indications of the conditions of the heart before and after treatment, shew that very marked improvement takes place in suitable cases.

Much stress is laid upon the necessity of personal supervision, and very careful watching of the effects produced. The conclusion arrived at, after reading the book, will probably be, that the treatment is of little value, except in the hands of those who have had considerable experience in it, which, in view of the comparatively few cases suitable from physical condition and financial considerations, the general practitioner will have difficulty in attaining.

Clinical Lectures on Diseases of Heart and Lungs. By J. A. Lindsay, M.D. (Balliere, Tindall & Cox). pp. 446. Price 9s. net.

These are clinical lectures delivered at the Royal Victoria Hospital, reprinted and revised. Lecture I. deals with the comparative value of the serial and direct method of investigation, and Lecture II. with the interpretation of history in disease. These are interesting and contain some excellent observations on various sources of error in diagnosis. The other lectures deal directly with the diseases to which the title refers.

Lectures III. and IV. deal very fully with the physical signs of lung disease; phthisis is dealt with in five lectures, a very good one being devoted to the value of early symptoms and the diagnosis before unequivocal signs are present. Under treatment—sanatoria and various health resorts are discussed, and there is much useful information not included in ordinary text books. Other lectures on lungs deal with rare pulmonary conditions—hæmoptysis and the treatment of pneumonia.

In the last half of the book, heart disease is very fully dealt with; there are lectures on physical signs, diagnosis, disorders of rhythm, and a very interesting discussion of some diagnostic problems and the significance of signs.

The last lecture deals with treatment. The author confesses to a somewhat limited personal experience of exercises and baths, the former of which he considers useful in some cases; of the value of the latter he is more doubtful. He quotes the opinion of several well-known authorities in this connection, which are, on the whole, favourable, with certain reservations.

The Nutrition of the Infant. By Ralph Vincent, M.D. (London: Ballière, Tindall & Cox.) pp. 285.

In this will be found a very full account of the proper feeding of infants and the disorders to which errors in the same may give rise.

The author goes minutely into the subject of "substitute feeding" and "milk prescriptions," and gives an excellent description of the methods of preparing those in use at the Walker Gordon Farm at Sudbury.

To most the chapter devoted to the treatment of summer diarrhœa and marasmus will be of interest.

The author insists very strongly on lavage of the stomach and colon in cases of epidemic enteritis.

The book, if somewhat long, will repay perusal.

The Medical Annual, 1904. (T. J. Wright & Co., Bristol). 7s. 6d. net, with Stereoscope, 2s.

This work still maintains its standard of excellence. On the whole, there is nothing strikingly original to chronicle for the past year, but most articles will be found worth perusal.

Biographic Clinics. Vol II. By George M. Gould, M.D. (Rebman, Ltd.). pp. 375, price 5s.

This is a fresh series of biographic observations in the same strain as Vol. I., from the point of view of an American eye specialist.

Although there is much in eye strain as a predisposing factor in the small and worrying ills of life, which in England, at any rate, is receiving consideration, yet one may be pardoned a little scepticism when asked to believe that all the petty ills and morbid fancies of our "litterati" were due to this factor alone, especially in the absence of direct clinical observations. Consciously or unconsciously, we think the author deduces more from his data than is to be logically conceded.

Sport.

Association Football.

Guy's v. Bart.'s.

Final of Inter-Hospital Junior Association Cup.

This match was played at Hale End on Monday, March 28th. There had been some misunderstanding between the teams as to the date of the match, which really ought to have taken place in the previous week. The consequence of this was, that seven of our team had left town for the vacation, and their places had to be filled by men who were playing for the first time this season, and consequently were somewhat done up before the end. Bart.'s were the heavier team, and their forwards playing a typical cup-tie game, took a lot of stopping when once they got going. We were the first to score, Messent taking the ball down on the left, centred nicely, and Sharpe put on the finishing touches with a really good shot. After this Bart.'s had the best of it, and managed to score three goals before half-time.

On resuming, Guy's, playing with the wind, pressed hard, and Sharpe reduced the margin with a hard left-

footed shot. The rest of the game was chiefly round their goal, but we could not score again, and consequently lost the Cup for the first time in the last three years.

Hockey.

Guy's v. Bart.'s.

Inter-Hospital Competition.—Semi-Final Round. Replayed Tie.

After drawing with Bart.'s on Monday, 29th February, this tie was replayed on the Athletic Ground at Richmond on Thursday, March 10th, and resulted in a win for Guy's by 4 goals to 0. The game was very fast, and for the most part evenly contested, but our defence was very sound, Archer being especially prominent at full-back. The forwards showed much more combination than last time, and by dint of short passing frequently nonplussed our opponents. Hughes played very well at outside right, and scored the first goal about a quarter of an hour after the start with a good shot from a difficult angle. From a good forward rush Wells scored the second goal after Bart.'s goal-keeper had partially saved; and Davies soon added a third. At half-time the teams crossed over with the score 3 to nil in our favour.

From the restart Bart.'s went away with a rush, and for a time pressed, but an excellent defence was put up by us, Knight and Archer being very good, Archer in especially clearing time after time. About half-way through the second half, Guy's again went away and added a fourth and last goal by Wells. No further scoring took place, and the game ended as stated. Wedd and Wells showed up prominently in the front rank, whilst Archer at left-back was the best of the defence. E. S. Norton at left-half marked his man well, and worked hard.

Chess Club.

GUY'S v. ST. GEORGE'S.

The third match in the Inter-Hospital Shield Competition was played on Wednesday evening the 23rd ult., at St. George's Hospital, and resulted in a win for Guy's by five and a half points to half a point. The following was the score:—

1	E. E. Rendle	1
2	E. R. Routley	½
3	H. Henderson	1
4	A. Vernon-Taylor	1
5	H. N. Eccles	1
6	C. Rudolf	1
	Total	5½

Swimming Club.

At the annual general meeting of the above club, held on Thursday, 17th March, 1904, Sir Alfred Fripp being in the chair, the committee was elected as follows. President: Sir A. D. Fripp. Vice-Presidents: Dr. Bryant, C. H. Fagge, Esq., J. Lewin Payne, Esq. Captain: R. B. Dawson. Vice-Captain: P. V. S. Pedrick. Hon. Sec. and Treas.: T. B. Layton. Representatives: First year, H. E. Alexander; second year, H. E. Perkins; third year, S. McK. Saunders; fourth year, F. Alcock; any, C. H. Reinhold.

Acknowledgments.

St. Bartholomew's Hospital Journal (April). Treatment (April). Clinical Journal (April 6th). Medical Temp. Review (April). Le Bois Medico-Chirurgical (March). Gaceta Médica de Costa Rica (February).

The Care and Feeding of Children. By L. Emmett Holt, M.D. (Syd. Appleton).

Calendar.

April, 1904.

Sat. 9.—Messrs. Golding-Bird and Dunn's take-in; Drs., N. H. Oliver and H. M. Langdale; Cl., G. A. Ticehurst.

Mon. 11.—Second Test Exam. in Dental Metallurgy for 1st Professional Exam for L.D.S. Eng.

Schedules for L.D.S. Eng. and 1st Professional Exam. for L.D.S. Eng., with the Certificates of Mechanical Dentistry already signed, to be left at the Medical School Office not later than this date.

Tues. 12.—Second Part of Cambridge D.P.H. Exam. begins.

Thur. 14.—Mr. Jacobson and Sir Alfred Fripp's take-in: Drs., H. C. Cameron and G. H. K. MacAlister; Cl., M. Louisson.

Mon. 18.—First and Second M.B. Durham Exams. begin.

Wed. 20.—Names of Candidates for Entrance Scholarship in Dental Mechanics to be sent to the Medical School Office by this date.

Thur. 21.—Messrs. Symonds and Steward's take-in; Drs., A. B. O'Brien and R. W. Allan; Cl., F. P. Hughes.

Fri. 22.—Third and Final M.B. Durham Exams. begin. Exams. for M.D. and M.S. Durham begin.

Birth.

SICHEL.—On March 30th, at The Lawn, Guildford, the wife of Gerald Sichel, F.R.C.S., late R.N., of a son.

Deaths.

COLGATE.—On March 19th, at Albury, Eastbourne, Robert Colgate, F.R.C.S., aged 85.

McPHERSON.—On March 30th, at Benwell Grange, Newcastle-on-Tyne, Malcolm E. McPherson, B.A., of Guy's Hospital, aged 25.

OLDMAN.—On March 19th, at Bletchingley, Surrey, Charles Edmund Oldman, M.D. Cantab., aged 56, of acute septicæmia.

Ed.—N. H. O.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 417.] APRIL 23, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	161–163
Diphtheria. Clinical lecture by Dr. F. Taylor	164–169
In Lighter Vein	170
Correspondence	171
Davies-Colley Memorial Book-Plate ...	171–172
Obituary	172
The Relation of Dental Caries to Disease. By Mr. Kenneth Black	172–179
Guy's Hospital Children's Christmas Tea Fund	179
Appointments	180

Passim.

ALL Guy's men will have read of Sir Samuel Wilks' ultimate convalescence with deep thankfulness, and the following letter from Mr. Symonds will show that by this time the patient may safely be said to have passed the convalescent stage. Mr. Symonds writes :—"I saw Sir Samuel to-day, and found him walking about the house and resuming his writing of correspondence. He has been out driving and walking, and is, in fact, quite well again. He is much interested in reading the various remarks in past numbers of the GAZETTE and other papers. A good deal of strength has yet to be gained, but the progress is all that we could wish for." In preserving so valuable a life, Mr. Symonds and Dr. Pye-Smith have earned the gratitude of Sir Samuel's many friends and admirers, both at Guy's and in the medical world at large.

WE have received the Treasurer's Report for the Year 1903, the reading of which, while it is calculated to impress one still further with the administrative skill of those who have the destinies of this Hospital most at heart, must at the same time increase the general conception of the enormous odds against which the governing body not only fight but even manage to make headway. The report will amply repay a full perusal, summing up as it does the work of an eventful year and forecasting developments in the not very distant future. Of course the financial deficit is the abiding crux of the situation, and with other institutions equally importunate in their demands upon the public ear, it must be with no light heart that the Treasurer's Office enters upon another financial year. The anticipation expressed in the last Annual Report, that in return for the successful outcome of the Hospital's efforts towards efficiency, adequate financial assistance would be forthcoming has not been realized, and 1904 finds the Governors with an increased burden of debt and in grave anxiety lest sufficient means to carry on the necessary work should not be forthcoming.

DURING the past year, and for the first time since 1884, all the wards came into use, and the sum total of In-patients treated (8,191) shows an increase of 100 over the numbers in 1902. It is perhaps hardly realised that Guy's is now ministering to some 2,500 more In-patients per annum than was the case ten years ago; this is in great measure due to the re-opening of closed beds, but acceleration of cure with our ever advancing scientific methods, better nursing and improved hygiene must play a large part in the

effecting of so enormous an increase. This acceleration of cure is, however, in the main, and not unnaturally, a surgical boast, for statistics go to show that medical cases have latterly been retained in the wards for a longer period than in former years. This, of course, merely means that the physician's *kudos* though every bit as legitimate as that of his surgical confrère, nevertheless rests upon a more subtle basis, namely, a slow diminution in the number of autopsies.

In rendering a just and full acknowledgment of the help afforded them by generous public men and some private individuals, the Governors have had to publish an imposing list of names. We venture to express the opinion that amongst the names of those who have contributed in any way to the improvement of the Hospital, that of Miss Constance Mudge, Sister in the Front Surgery, deserves a very high place on the list. In spite of the fact that she was at one of the busiest posts a sister can be called upon to fill, she nevertheless found time for a striking personal appeal in the columns of the Press, and managed to raise a fund of upwards of £800 for the purpose of providing adequate shelter for the women and children who daily crowd the Front Surgery. This effort must have entailed a very large amount of extra work and worry, and though Sister Surgery's best reward will doubtless be to see her object achieved and the renovated Front in full working order, yet we cannot refrain from expressing what must be the general feeling of satisfaction, that it is due to a Guy's sister that so desirable an improvement has been made.

As regards the needs of the educational department of the Hospital, that which will most interest all Guy's men, both past and present, is the scheme of remodelling the school buildings and museums of which the new Physiological block is but the first instalment. At the present moment the next move anticipated in this direction is the building of a lecture theatre in connection with the new museum, and then, says the Report, it will be possible "to demolish the present block of buildings containing the old museum"! For this demolition many sigh as they sit cramped in the old anatomical theatre, and now at last it is on the horizon of possibilities. Alas that we, the present generation, can only rejoice to see the day approaching!

In the death of Dr. Charles Edmund Oldman this Hospital has lost another distinguished man. Dr. Oldman was studying at Guy's in the early seventies and, already an M.A. of Cambridge, took his M.D. degree in 1877. He commenced practising in Spalding, Lincolnshire, his native county, but was soon appointed Medical Officer to the Western District and Workhouse of the Godstone Union, and later became Public Vaccinator and Medical Officer of Health to the Godstone Rural District Council. He was held in the highest esteem, both as a private practitioner at Bletchingley and as M.O.H. and his death from blood-poisoning at the age of 57 has caused the deepest regret in the neighbourhood.

We note that Dr. Farrant Fry, whom many old Guy's men will remember, has established a Medical and Surgical Home at St. Leonards, and has been fortunate enough to secure the services of Miss Finnemore, recently Sister Martha at Guy's Hospital. It is certain that any Guy's man who may send his patients to this home, will need to have no fear of their treatment at the hands of so excellent a coalition.

As men pass on from year to year in their hospital curriculum, it is interesting to notice "how swollen ambitions dwindle." In the chemical laboratory and in the dissecting-room there are very many more with faces set towards Harley-street and elsewhere west of Oxford Circus than one would find from among a revision class for the final Conjoint examination. By that time your ordinary man, although he may once have owned his castles in Spain, is nevertheless content to ask with the octogenarian "barely a sup of gruel and a fire of dry sticks, and thanks you as for his full allowance and right in the common good of life, hoping nobody may murder him." And so in time does general practice swallow him up, and instead of treating the Ducal knee, or even (with bated

breath) the Royal appendix, he comes down to plain Mrs. Brown and the almost inevitable baby, who in all probability do not suffer for their dear doctor's early soaring. What, then, is the moral of this observation, but that general practice should be earnestly regarded as the probable goal by all the less buoyant spirits, and even by some of the aeronauts who may be blessed with more humour than their fellows. In view of this practical necessity, we welcome the "Letters from a G. P.," which appear elsewhere, noting at the same time, that although an M.D., London, and apparently at one time a holder of house appointments in our midst, he can yet in his worldly wisdom, see the value of qualifications other than clinical knowledge.

The announcement in our last issue of a coming competition in our columns, has caused no small amount of comment. In the straightforward paragraph to which we refer, many, with a great parade of sarcasm, affected to see mere starving journalism desperate for copy, and careless of truth. A few there were who went so far as to hint that any suggestion of expenditure on their part in the way of a possible entrance fee, would be met by them with the coldest of refusals, enigmatically adding that the credentials of some competition editors might probably make interesting reading from the point of view of criminal law. Thus, in this also, is the Hospital a mirror of the mighty world, for ever belittling noble aim and high endeavour, and distrustful of even the paltriest demand on its miserable purse. Let us then at once state that this competition is no Chimaera, that entrance for it entails no payment of a fee, and that as regards the intellectual strain likely to be involved in the process, all allowances have been made, and after much whittling and selection, it is calculated that no brain will be needed on the part of the competitors. Having thus disposed of all evil-speakers and slanderers, it may be as well to explain the exact nature of the competition.

Under the heading of Gazette Prize Competition on page 170, will be found some few quotations from Shakespeare, each of them having reference (not of course in the original, though no doubt the author would have felt honoured) to some well-known person on the Hospital premises; that is to say, they in some cases describe a certain person's mental attitude, whilst in others, where mental attitude, politely speaking, is not so strongly marked, the quotation will refer baldly enough to physique and physical attributes and capabilities. Each quotation is numbered. The reader who shall send in the largest number of correct names, numbering each with the number of the quotation that in his opinion fits the person in question, will in no way lose his reward, which will consist of one guinea in paper money or coin of the realm. Every competitor must address his envelope to the Competition Editor, and also *must* sign his name. In the event of the successful competitor wishing to remain anonymous, much as it will detract from the interest of the affair, his desire will be respected. The result will be published in due course. All our readers are invited to join in this amiable recreation, seeing that it is, as it is, quite innocuous, and should it prove successful, it will be the first of a series.

Cricket is now looming large in the near future, and since disaster has befallen us in the Rugby field, we begin to cast an anxious eye in the direction of the Cricket Cup. One or two invaluable men fall out of the eleven this year, and it is earnestly hoped that there will be a good show of freshmen at the trial matches, of which three will shortly be arranged. It would seem, that in spite of the fact that there are gaps in the ranks, we can still turn out a good batting eleven, but the bowling will be a weaker point even than last year, while the wicket-keeping prospects are already causing the committee much searchings of heart. Regular attendance at the practices will go far towards making the coming season a successful one, but if a few of the prominent cricketers could be well shaken as a preliminary precaution, perhaps the season's prospect might assume a rosier tint. The cricket club are too fond of letting the work rest mainly in the hands of one or two men, and the sooner a little *esprit de corps* makes itself felt, the better for Guy's cricket, and the better, quite incidentally, for the sporting reputation of a few gentlemen who shall remain nameless.

Diphtheria.

CLINICAL LECTURE By Dr. F. TAYLOR.
November 28th, 1903.

Gentlemen,—The patient about whom I am going to lecture to-day was admitted on November 20th for laryngeal obstruction and stridor. She was a fairly well nourished girl, æt. 3 years, who had always had good health. Yesterday the mother noticed that she was not well and that she did not take her food; she says the child complained of her throat. She gave her some liquorice powder and this morning noticing that there was difficulty of breathing brought her to the hospital. The child was admitted at once, and the report is as follows:—She is somewhat pale and has marked stridor. There is a little sucking in of the lower ribs, but examination of the fauces reveals no evidence of a membrane. The tonsils are somewhat injected. Temperature 100.8°, pulse 140. A diagnosis of laryngeal diphtheria was made and 9,000 units of antidiphtherial serum were injected. The patient was seen two hours later, when the stridor and sucking in were more marked; the child's face had a dusky hue and she wore an anxious expression. I saw her at this time and directed that tracheotomy should be performed without delay. Mr. Steward was called in and he intubated the child at 5.30 p.m. She coughed for over an hour afterwards, and became very exhausted; 2 ♏. of liquor strychninæ were given, and the child gradually became better and eventually slept. She was fed by a nasal tube and 6 ozs. of milk and 20 ♏. of brandy were given at the usual intervals; 3,000 units of antitoxin were injected at night. On the 21st 3,000 more were given, and the intubation tube was removed; but at four in the afternoon the breathing became very bad and there was much sucking in. An attempt was made to replace the tube but it failed, and tracheotomy was performed. The child was rather collapsed after the operation and 2 ♏. of liquor strychninæ were given. The nasal feeding was continued.

I need not continue this report: what I have to say is sufficiently introduced by the history so far. The child still lives, and so far as the diphtheria is concerned we may hope that the disease is subsiding, and will probably have disappeared in a short time. The difficulty that remains is one which occurs every now and then, namely, that after the obstruction in the larynx has been relieved by intubation or by tracheotomy, and when it is thought that the tube may be safely removed, and it is removed, the patient does not breathe as well as it is hoped, and some time has to elapse before the patient can be safely left without it.

The word "diphtheria," as some of you may know, comes from the Greek word διφθέρα, which is commonly described as being meaning a membrane. I have referred to Liddell and Scott's Greek dictionary, which gives as the meaning of διφθέρα a prepared hide or piece of leather, anything made of leather, hence a leathern garment, a wallet, a bag. The word membrane does not occur. However, the word diphtheria is only of comparatively modern use. I think it was only introduced by Bretonneau somewhere about 1850. For us, the lesion of diphtheria is some sort of deposit produced from the tissues of the body which can be stripped or taken off, or can appear in the form of a more or less continuous layer of tissue, and in that sense may be termed a membrane.

It is a more or less detachable layer of material, having a basis of tissue element in it, but not much more than that. This formation of membrane occurs not only on the surface of mucous membrane, but also on any abraded surface. For instance, you may have the common diphtheria taking place upon the throat, the fauces, the tonsils, the soft palate, the uvula; but it may also occur on the nasal mucous membrane, on the conjunctiva, on the vaginal mucous membrane, the laryngeal, the tracheal, and the bronchial mucous membrane. And there are allied processes which take place upon the mucous membrane of the intestine and stomach, which, however, I believe are not precisely of the same nature, that is to say, of the same bacterial origin as the diphtheria with which we are dealing at the present moment. This diphtherial membrane may occur on the surface of wounds, and cases occur every now and then in which patients who have had diphtheria of the throat and of the larynx and have had tracheotomy performed, have a diphtherial membrane forming on the surface of the tracheal wound, a condition which very much enhances the danger of the case, and perhaps indicates a low resisting power on the part of the patient, or a greater virulence of the microbe. Of late years we have learnt nearly exactly what is the organism which causes diphtheria, namely, that known as the Klebs-Loeffler bacillus, about which many new facts have been elicited since it was

first described. For instance, there are different strains of the bacillus, the long and short forms, and other varieties, but, at any rate, we know that diphtheria is a bacillary disease.

The next thing we have to recognise is that this disease does not always produce a membrane. Under different circumstances, or in different stages, the disease produces different effects upon the mucous membrane. I may remind you here that the mucous membranes in general are subject to different forms of inflammation, which have been called catarrhal, diphtherial, gangrenous and suppurative, determined no doubt by different micro-organisms or by variations in the resisting power. In quite an early stage of diphtheria you may have a purely catarrhal condition resulting merely in the production of mucus. Very often, and especially in hospital practice, we do not have the opportunity of seeing these cases early; they come when they are very bad, when there is some difficulty of breathing or soreness, or trouble in swallowing, and perhaps when they have already been for some time under the care of a medical man outside. As the case gets worse the medical attendant sees that the danger is greater than he has the opportunity or means of dealing with, and the case comes under our care. But sometimes when you see these cases early, as I remember one myself, the patient presents a little reddened surface of mucous membrane with a greyish mucous secretion, that is, a purely catarrhal condition. But at some stage or other in nearly all you get what is considered is the typical condition of diphtheria, and that I shall refer to presently. Thirdly, there may be a deep sloughing of the tissues, a gangrenous condition of the mucous membrane, due primarily to the same diphtherial microbe.

What is the real typical, characteristic membranous diphtheria like? How are we to know the disease in its earliest conditions? Apart from this mucous condition which is sometimes seen, I think there is no doubt that the first characteristic thing you see is a white patch. At one time very much was made of the "washleather" appearance of diphtherial membranes. The washleather appearance is very rare. The bright yellow colour, whether clean or dirty, of washleather as I am familiar with it, is not very commonly represented in diphtheria at the present day. I think very likely that is due to our more efficient modern treatment of the disease, to its more prompt treatment, and therefore the avoidance of more severe conditions. The white patch which you first see is generally on the tonsils, oval in shape, creamy white, and moist on the surface. Is there any difficulty in being sure that a case of this kind is really diphtheria? Is that patch likely to be confounded with any thing else? Undoubtedly it may be confounded with what is known as follicular tonsillitis. The tonsils are organs which are liable to infection in a very striking way, and we know at least three well-marked conditions of inflammation of the tonsils, namely, follicular tonsillitis, diphtherial tonsillitis, and suppurative tonsillitis. The old word "quinsy" is now generally reserved for suppurative tonsillitis.

In suppurative tonsillitis there is, as a rule, no appearance of a membrane or any change on the surface, except increased vascularity and redness, and the whole tonsil gets bigger; there is œdema of it and of the neighbouring parts, and ultimately suppuration takes place in the depth of the tonsil. That does not happen in diphtheria. In follicular tonsilitis there are inflammatory products formed in the follicles or crypts in the substance of the gland, and small patches appear on the surface which are often of a yellow colour, due to a collection of leucocytes and epithelial cells. As long as there are a number of separate yellow points on the inflamed tonsil, and both tonsils are affected at the same time, though one generally worse than the other, I think you may be sure you have follicular tonsillitis and not diphtheria. But in the follicular inflammation the process may be much more intense, and then you get the products merged into one mass, which is often bright white, with much surrounding redness of the tonsil; and then the distinction from naked-eye appearances is almost impossible and difficulties often arise. If you have a condition such as I have sketched and you wish to deal with your patient promptly, you should have a bacteriological examination of these products in order to find out whether there are Klebs-Löeffler bacilli or other organisms, such as streptococci.

If this inflammation extends beyond the limits of the tonsil you may be sure you have not got simply a follicular tonsillitis, but *diphtheria*. We often meet with cases in which there is a large white patch over the tonsil which spreads to the pillars of the fauces, and it is very liable by simple contact to infect the side of the uvula, so that you get there also a white patch. Then there may be one on the other side, and later a whole mass of diphtherial membrane, spreading perhaps to the posterior part of the pharynx. It is in those cases you

may get the yellow appearance which has been likened to washleather, and it is probably produced by the persistence of a large and extensive mass of this necrosed tissue, imbibing perhaps coloured matter from the food, or from small quantities of extravasated blood; that is, rather a dirtying of the material which is formed on the fauces than the colour of the material when first produced. Around the white patch the uncovered mucous membrane is deeply reddened. In severe cases there is often extension to the nose or to the larynx, and in both of those last regions extension of the process is a very important and indeed dangerous condition. But patients may have severe diphtheria of the throat without extension to the nose or to the larynx, and it may yet be fatal. Nasal diphtheria has for a long time been represented as of peculiar malignancy, with a very bad prognosis. But cases of nasal diphtheria are not necessarily fatal, and I think the fatality of that form has been somewhat overrated. But when saying that, I must admit that this idea took origin at a date anterior to the use of diphtheria antitoxin, and therefore I am forming an opinion at a much later date and at a much more favourable period in the history of the disease. In nasal diphtheria there is some stuffiness of the nose and thin dirty, yellowish-brown sero-purulent fluid runs from the nostrils. It is of an extremely irritative or infectious nature, for the skin below the nose is commonly excoriated and reddened as it flows over it.

Still more important is the extension to the larynx. Not infrequently it happens three or four days after this disease has commenced that the patient shows indications that the larynx is involved by the diphtherial process, and the indications are of this kind. The patient has an irritating cough, he seems to be constantly coughing, though without expectorating much, if at all. It is an imperfect, husky, cough, and does not, apparently, succeed in clearing the respiratory passages of what is obstructing them. It is sometimes a little clanging, but not a metallic cough. Later, perhaps, it gets more noisy or "croupy." Besides the cough there is evident obstruction of the respiratory passages, and there is sucking in of different parts of the thorax during the descent of the diaphragm.

When a patient comes to you with diphtheria or laryngitis, or any cough, or difficulty in getting the breath, you should inspect the chest, to see exactly what is taking place. In this child, before it was operated upon, we saw that all the soft parts were drawn in at the time of inspiration. The explanation is as follows:—the diaphragm descends in obedience to its stimuli from above, and the vacuum which it tends to produce cannot be filled by the entrance of air through the natural passage, the larynx; in consequence the atmospheric pressure, operating upon the soft parts of the chest drives them inwards to fill up the space which the descent of the diaphragm creates. Those parts are the episternal notch, and the parts between the sterno-mastoids, the triangles of the neck just above the clavicles, the epigastrium, which is commonly retracted in a striking way, and to a less extent the intercostal spaces. When the condition is very severe, not only the epigastrium, but the lower end of the sternum is forced in, and there is a marked degree of distortion in the chest. I am speaking of children, for it is mostly in them that we see the disease; their chest is soft, and the action of the diaphragm is more pronounced in its effects. This sucking in of the chest is a very important indication of the amount of obstruction present. But I should not like you to think that obstruction of the larynx is the only thing which may produce sucking in of the chest; it may be produced by any obstruction at any point in the respiratory passages.

In laryngeal diphtheria, the so-called membrane is deposited upon the surface of the larynx, upon the vocal cords, and epiglottis, and then spreads down the trachea and produces a membrane there, causing analogous changes in the whole of the respiratory tract. It is interesting to note that the membrane produced in the trachea and bronchial tubes is somewhat different from that on the fauces; it is less adherent, and is probably produced in the superficial layers of the tissue. This is perhaps dependent on the different character of the mucous membrane in the two parts. If you succeed in tearing off the membrane from the fauces—which one rarely attempts nowadays—you leave a bleeding surface behind. With regard to the trachea, as you will see at the post-mortem examination of fatal cases, the membrane is detached already, and will separate almost entirely. The layer of deposit in the bronchial tubes is even less membranous than in any other part, and becomes almost purulent: that is, the diphtherial process in the bronchial tubes produces rather a muco-purulent secretion than a definite membrane. Going further still, there is produced in many of these cases a condition of broncho-pneumonia, or lobular pneumonia scattered over the chest; and in the cases where the disease has been fatal that is nearly

always found. From time to time one gets a case in which the physical signs indicate lobar pneumonia, but in most instances the pneumonia is of broncho-pneumonic type.

I do not think that in the present day you are troubled in the same way with the question of croup as we were years ago. Before the discovery of the Klebs-Löeffler bacillus it was a great question whether the condition called "croup" was or was not diphtheria; and in the books of thirty years ago or less you will find the point discussed, and the means of distinguishing one from the other are given. I have told you that faucial diphtheria may spread up to the nose and down to the larynx. But there are cases, of which this child is an instance, in which the larynx is attacked before the throat, and others in which the throat is not attacked at all. The notes show that in this case there was no membrane on the fauces. Certain it is that the disease may affect the larynx and trachea, and may kill the patient, without spreading to the fauces. The question then arises: A child has laryngitis, it gets ill, it begins to cough and bark and is short of breath, its chest is sucked in and you do not know exactly what is the condition of the air passages. You may ask, Why not use the laryngoscope? It was not used in this case, and I think rightly, because it is very difficult, indeed, even to a professed laryngologist, to inspect the larynx of a small child suffering from diphtherial laryngitis, and probably examination would have given very little information. Indeed, for the diagnosis we have to rely much upon experience.

For a long time the word "croup" has been used, not only in English medical practice, but by the English public, to indicate a noisy cough obviously arising from disease of the larynx, and in most cases due to a laryngeal inflammation. The realization of the infective nature of these diphtherial throats was a comparatively recent matter, and when it was seen that this diphtheria of the throat might extend to the larynx, then came the question whether those cases in which the throat was not affected but only the larynx, were of the same nature as the faucial form. So long as no bacillus was known in the disease, the means of determining the question were very small. Even so short a time ago as twenty-five years since, a large committee of the Medico-Chirurgical Society reported on the subject, and one of their conclusions was, that membranous laryngitis "May arise in connection with common inflammation or with specific disorders of several kinds, the most common of which in this relation is that which produces similar change elsewhere, and is recognized as diphtheria."* That is indeed the accepted idea now, and it has received confirmation in many ways.

Experience shows that in the majority of cases in which patients come to you with a history such as we had here, the case is one of diphtheria. To meet the other position one ought to say this: That there is practically no *contagious* membranous affection of the larynx which is not diphtheria; there is no *contagious* croup which is not diphtheria. Of course there is laryngitis, which need not be contagious in the same way as is diphtheria, unless we make a reservation with regard to scarlatina or measles. But at any rate a *contagious* membranous laryngitis is a part of some recognised infectious disease such as diphtheria, and not a special complaint peculiar to the larynx. You may have a catarrhal laryngitis which produces intense inflammation of the larynx and leads to noisy cough, and may be fatal unless tracheotomy be performed to relieve the difficulty. That will be catarrhal, and may be in respect of symptoms, croup, and perhaps not a membranous inflammation. It is often stated that you may have—and that is a very strong point with the "croupists"—a membranous inflammation of the larynx produced by the accident to which some infants are liable, of swallowing hot water from the kettle; that is a membranous laryngitis, but it is not diphtherial, though it may be fatal, and it is not contagious. But if you have a disease which has been produced by contagion and can produce contagion again, that is diphtheria, and not any imaginary croup. You may have catarrhal croup, hot-water croup, if you like, and spasmodic croup, the nature of which is perhaps more doubtful. A mother often says her child is subject to croup, and that it has attacks in the winter; you will know that the child has not had diphtheria half a dozen times, but that it has been seized at night with difficulty of breathing and a croupy cough, with perhaps more or less redness or blueness of the face, has been apparently in a dangerous state, but that then the condition has passed off. Some of those cases are probably acute catarrhal conditions of the larynx; others possibly may be produced by spasm of the laryngeal muscles, and are true spasmodic croup. I think the general belief is that they are spasmodic conditions grafted upon acute catarral laryngeal conditions.

* Medico-Chir. Trans., Vol. 62, 1879, p. 32.

However, as a rule, the condition is temporary; a few hours, or half a day, may suffice to make the child better. These cases are not contagious. As a matter of historical interest, it is curious that the technical term which was adopted years ago for croup was "cynanche trachealis," and the writers made much of the tracheal difficulty, and not so much of the laryngeal. I do not know whether it was defective observation with regard to the larynx, or whether they recognise post-mortem the separable tracheal membrane more than the condition of the larynx. But of late years the condition of the larynx has been the one most impressed upon writers and observers in this matter.

There is another point, which made the difficulty of distinguishing between diphtheria and croup somewhat greater, and which has not been satisfied even at the present day. It is this. You may know that certain sequelæ are apt to follow faucial diphtheria, and especially two, albuminuria and diphtherial neuritis or paralysis. It is very common to have albuminuria in faucial diphtheria. The kidneys are inflamed no doubt as a result of the absorption of the diphtherial toxin. This is one of the diseases in which the microbes are found in localised areas, and in which their toxins circulate in the body and produce the fever and other disturbances. The bacteria may spread by simple contiguity, but, as I have shown, they may keep to one limited area, so that a faucial diphtheria may not even become laryngeal, and *vice versâ*. Occasionally, in a smaller number of cases, paralysis occurs as a result of the influence of the toxin upon the nerves, and perhaps also upon the cell-bodies of the neurons in the spinal cord. Those two sequelæ or complications of diphtheria are relatively common in faucial diphtheria, and relatively uncommon, or even rare, in purely laryngeal diphtheria. It is to be regretted that we have not been able to get a specimen of the urine in this case to see if it conforms to the rule. The difference between faucial and laryngeal diphtheria as regards sequelæ naturally made a great impression upon those who thought that there was a great difference in the nature of the two conditions, and it was considered to be an effective weapon in the contest.

With regard to diagnosis, we have to distinguish a case of faucial diphtheria from one of follicular tonsillitis, in the way I have mentioned; and we have to distinguish laryngeal diphtheria from catarrhal laryngitis and spasmodic croup. Our means of diagnosis in the case of the fauces are better than in the case of the larynx. In the faucial form we are able to get on a swab some of the material for bacteriological examination, and to make cultures from it. If it is follicular tonsillitis the diphtherial bacillus is absent. Of course in the laryngeal form there may be cases where it would be of great advantage to get a swab and make a bacteriological investigation; but it is more difficult and, as a rule, is not attempted. So that in our case we have no proof that it is diphtheria except that of experience; namely, that we have seen dozens of such cases, some of which have recovered and others have died, and in the latter the evidence of diphtheria has been unequivocal.

We now come to the treatment. I shall not enter upon the whole subject of antitoxins and serums; the profession, I think, is pretty much at one on those points. It has been satisfactorily shown that the value of antitoxin in the treatment of diphtheria is very great indeed. It comes out in two ways, as has been shown, especially by reports of the Metropolitan Asylums Board; first, in the improved mortality statistics of diphtheria; and secondly, in the improvement in the statistics of mortality in cases of laryngeal diphtheria, which formerly was the most fatal form. We who have watched for a number years cases in hospital have that impression prominently before us. I know that fifteen or twenty years ago there were numbers of physicians and surgeons in London who looked upon tracheotomy in diphtheria as perfectly hopeless. I think they took an unduly gloomy view of it. To one of them who said so, I was able to show five or six cases who had been operated and were then running about Clinical ward. It was a lucky accident; some time afterwards I could not have done so, as they were dying in sixes instead of living in sixes. One would have one or two cases relieved by tracheotomy, then breathing getting difficult again, then the tubes cleaned out, and in another two days perhaps the patients would be dead. Remember that tracheotomy only relieves the laryngeal difficulty and does not prevent the spread of diphtheria to deeper parts which, with the absorption of the toxins kills the patient. You have to remember that tracheotomy is simply a temporary measure, the advantage of which may be entirely neutralized if the disease spreads down into the bronchi. Nowadays, at the same time as you operate to relieve the pressing danger of asphixiation you give an antitoxin which antagonizes, in part, the diphtherial poison. A great number of these cases now

recover. Our patient has certainly recovered as far as the diphtheria is concerned.

The first two cases for whom I ordered antitoxin, I think just ten years ago, came into the hospital within a day or two of each other, both were injected with antitoxin, though not in such large doses as are given now, and both recovered after having been operated on. That experience was not unexampled, but it was rather unusual, and from that day we have seen great improvements in this respect. You have heard that 9,000 units of antitoxin were first injected in this case, and that 3,000 units were given on two succeeding days, so that altogether the child had 15,000 units, and that is about the usual quantity. You must know that the dose of this remedy is not to be determined by the age of the patient, but by the severity of the disease, and the earlier you use the antitoxin the greater is your chance of curing the patient. One objection given against the antitoxin is that it causes an erythematous rash, but I think you will agree that that is a minor matter. Another objection was that patients who had the antitoxin were more liable to have albuminuria and paralysis than those who did not have it.

One perhaps might rather prefer to live with albuminuria or paralysis than to die for the want of antitoxin, and I think most mothers and fathers would say so too. One answer to that objection is that the fact that the paralysis and the albuminuria are not proofs that the antitoxin has done any harm, but simply that the toxins of diphtheria were exceptionally virulent. At any rate, the patient has recovered and had his life saved, even though the albuminuria may persist. Further, in many cases the albuminuria and the diphtherial paralysis recover in course of time. Diphtherial paralysis is sometimes fatal, but it rarely lasts as a chronic condition. Another objection to giving diphtheria antitoxin is akin to the objections made by anti-vaccinationists, namely, that it is a nasty thing to inject your children with a serum from a horse. I do not think any medical man would regard that as a serious objection. And I think we might point out to those sentimental objectors that such argument applies equally to the use of most kinds of animal food, and especially to such things as tripe and sheep's kidneys and chickens' gizzards.

Now, are there any local measures which one wants to employ? There is no doubt that local measures in the treatment of diphtheria have become of much less importance since the use of antitoxin. What one knows with regard to antiseptitics is, that there are few or none of them which will destroy microbes without also destroying the tissues in which they lie. Therefore the antiseptic treatment of the throat in diphtheria is not very vigorously pursued at the present day. Before the introduction of the antitoxin all sorts of methods were tried, the application of chlorine, iodine, permanganate of potassium, sulphur, and other drugs, but one always felt that such measures were very inadequate, that they could do little beyond destroy some of the surface microbes. Even nowadays these drugs may be employed for the purpose of keeping the part clean and preventing putrefaction of the inflammatory products.

As a rule it is the better plan to leave the membranes alone, or at least not to attempt their removal. The influence of the antitoxin in a favourable case is to produce a gradual shedding of the membrane, and the throat is soon restored to its normal condition.

With regard to the relative dangers of throat and laryngeal diphtheria, the immediate risks of the laryngeal form are very much greater.

I will not discuss the relative advantages of tracheotomy and intubation. It is a surgical question, and I will only point out that intubation had here a temporary success, but that ultimately tracheotomy had to be performed.

Pass List.

First Conjoint Examination, April, 1904.

Part I.

Chemistry.—R. Beadnell-Gill, S. H. Browning, C. M. Craig, H. W. Heasman, O. G. Iliffe, E. D. R. Jacob, J. McBride, H. R. Mullins, R. G. Oram, W. H. Plowman, W. H. Watson, F. J. Wheeler.

Part II.

Pharmacy.—J. W. Dadd, A. W. Eyles, R. Franklin, R. S. Harper, H. H. Jenkins, L. Myer, O. S. Norton, W. S. Orton, R. M. Rendall, D. H. Richards, G. C. F. Robinson, H. W. B. Walling.

Part III.

Elementary Biology. — S. H. Browning, C. M. Plumptre, H. C. Pugh.

Second Conjoint Examination, April, 1904.

A. Davidson, M. M. Earle, C. F. Leipoldt, E. P. Minett, E. H. Paterson, E. N. Plummer, A. T. Rivers, S. McK. Saunders, H. Joste Smith.

In Lighter Vein.

GAZETTE PRIZE COMPETITION.

William Shakespeare, born April 23rd, 1564.

"All kind of natures
That labour on the bosom of this sphere
To propagate their states."

The following competition is open to any reader. The quotations refer in all cases to people about the Hospital, and range from the highest to the lowest, for the Competition Editor, like another dignitary we might mention, "also takes an intimate interest in the worm."

RULES.

1. There is no necessity to repeat the quotation, simply put the number, coupled with the name of the person to whom it is supposed to refer.
2. Send all answers to the Competition Editor, Gazette Office.
3. Sign your name.
4. See that your lists are sent in by Wednesday, May 4.
5. Only one list may be sent in by each competitor.
6. A list of correct answers is in the possession of the Editor, and will be rigidly adhered to.
7. The prize consists of ONE GUINEA.

1. You have shewed yourself a wise physician.
Merry Wives of Windsor, i., 4.
He is knight dubbed with unhatched rapier and on carpet consideration.
Twelfth Night, iii., 4.

2. A hungry, lean-faced villain,
A mere anatomy.
Comedy of Errors, v., 1.

3. He is a scholar and a ripe and good one.
Henry VIII., iv., 2.
O good old man! How well in thee appears
The constant service of the antique world.
When service sweat for duty not for meed.
As you like it, ii., 3.

4. He draweth out the thread of his verbosity finer than the staple of his argument.
Love's Labour Lost, v., 1.

5. For though she be but little she is fierce.
Midsummer Night's Dream, iii., 2.

6. I wonder that you will still be talking . . .
Nobody marks you.
Much ado about nothing, i., 1.

7. Here will be an abusing . . . of the King's English.
Merry Wives of Windsor, i., 4.

8. Why man he doth bestride the narrow world
Like a colossus. *Julius Cæsar., i.*, 2
Some are born great, some achieve greatness, and some have greatness thrust upon them. *Twelfth Night, ii.*, 5.

9. His worst fault is that he is given to prayer; he is somewhat peevish that way; but nobody but has his faults;—but let that pass.
Merry Wives of Windsor, i., 4.

10. The insolence of office. *Hamlet, iii.*, 1.

11. She is of so free, so kind, so blessed a disposition. *Othello, ii.*, 3.

12. Souls and bodies hath he divorced.
Twelfth Night, iii., 4.
All swollen and ulcerous, pitiful to the eye,
The mere despair of surgery he cures.
Macbeth, iv., 3.

13. And soon at supper time I'll visit you.
Comedy of Errors, iii., 2.

14. God made him, and therefore let him pass for a man.
Merchant of Venice, i., 2.

15. My books and instruments shall be my company
To look upon and practice by myself.
Taming of the Shrew, i., 1.
Such men as he are never at their ease
Whiles they behold a greater than themselves.
Julius Cæsar, i., 2.

16. Ask God for temperance; that's the appliance only
Which your disease requires.
Henry VIII., i., 1.

17. A fellow of infinite jest, of most excellent fancy. *Hamlet, v.*, 1.
Make false hair and thatch
Your poor thin roofs.
Timon of Athens, iv., 3.

18. Egregiously an ass. *Othello, ii.*, 1.
That he is mad, 'tis true. *Hamlet, ii.*, 2.

19. Faith, thou hast some crotchets in thy head now.
Merry Wives of Windsor, ii., 1.

20. Let me have men about me that are fat;
Sleek headed men and such as sleep o' nights. *Julius Cæsar, i.*, 2.

21. Every man has his fault and honesty is his.
Timon of Athens, iii, 1.

22. I have done the state some service, and they know it. *Othello, v.*, 2.

23. For though I am not splenetive and rash,
Yet have I in me something dangerous.
Hamlet, v., 1.

24. He will be talking; as they say, when the age is in the wit is out.
Much ado about nothing, iii., 5.

TIMON.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Letters from a G. P.

SIR,—Many things have been written for our learning beside the Holy Scriptures, which fact I discovered early in my hospital career. It remained for me to discover since then that there were many other things to learn on which nothing was written. Like some other people, I left the Hospital a guileless youth and the toils of general practice gat hold on me and developed the simple cunning with which I had been endowed. I suppose it dawns on most men after the Final that the amount of real knowledge they possess is not great, and if they go on and work as a Resident, they should have enough moral courage to own it. And when left to their own resources in general practice, they will find that their cunning (call it common-sense by all means if that is more stately) will be a much better weapon than the shreds of knowledge of which they are possessed. One naturally wonders, then, if the present system of education is best fitted to develop our most useful gift. It is risky work, an attack of this sort, but are we not in danger of attaining a little skill with a vast number of methods in the present day. I often wonder if a medical ward clerk, for instance, would not learn more in his first three months if he was debarred from the use of the stethoscope. This instrument is of course invaluable in diagnosis, yet the strength and rate of the pulse, the amount of the urine and the sleeping position of the patient will all tell us more about the prognosis, which is the one thing the patient's friends care most for. There again, I think we might well improve on our teaching. As far as I can remember, prognosis used to be a matter of whether the patient would live or die, and if I only remembered that it was only quite an off chance of his dying, say something under five per cent., I was quite happy. But your patient will want to know how long it will be before he can go to his work, and whether he will be able to dine with the Brown's in a week's time. It is the matter of greatest moment to the general practitioner, and he is taught nothing of it. Prognosis certainly has to be acquired by experience, but intelligent teaching on the subject would be invaluable to the student even if he had to sacrifice a blood-count. We cannot all attain perfection with many methods and instruments, and it is better, that being so, to master a few. The ophthalmoscope, for instance, is splendid, if you really understand errors of refraction. The ophthalmic surgeon is a stony hearted individual, and has been known to report astigmatism when slight blurring of the disc had made a great man diagnose meningitis. After all he may have possibly been right in his diagnosis, for some consultants are wonderfully expert with the ophthalmoscope. Several cases, I have known of, with marked retraction of the head and signs of cerebral irritation, have justified the consultant concurring with the diagnosis of meningitis, and this on account of his skill with the instrument. He just peeped through the minutely contracted pupils by the light of a small candle and saw a choked disc, which of course clinched the matter.

Next to the prognosis, I suppose the question of diet is the most difficult to answer, and to be on safe ground a beginner would almost condemn the patient to be a diabetic, if that were possible. Feeding, I know, is well taught by some physicians, but can we say the same when we come to the question of what the patient may drink? Do not recommend anyone toast and water, much less order it if you would have him love you; and the suggestion of soda and milk as a dinner drink is not always as well received as it might be. It may occur to you that wine may be classified in other ways than good and bad; and a gouty old gentleman who insists on drinking port, may rank your knowledge higher than he otherwise would, if you tell him that light port would be better for him than a vintage wine. He will probably have bought the experience that champagne is not a good lubricant for his toe-joint, and also that hock is nearly as bad, but he may be able to make his heart glad with moselle.—Faithfully yours,

WORLDLY WISEMAN, M.D.

Davies-Colley Memorial Book-Plate.

THE Plate which we published with the last number of the GAZETTE was a reproduction of the book-plate of the Davies-Colley Memorial. The plate was designed and engraved by Mr. C. W. Sherborn, whose work as an engraver of book-plates is world-renowned, and the present example of his skill will bear comparison with any of his previous productions. It may be remembered that the Committee of the Davies-Colley Memorial Fund determined to purchase books for the Library with the annual income derived from the capital sum subscribed, these books to be kept in a special case, and to bear the book-plate mentioned. There is no doubt that as years go on this collection will become an imposing one, and will form a most fitting memorial. It is hoped that the books purchased by this fund will be important books of

reference, atlases and illustrated monographs, such as the Library might not acquire by the ordinary method. It has not been found possible to present a copy of the actual book-plate to all the subscribers, but it was thought that they might like to see what the plate was like, and so we have ventured to publish this reproduction. We may mention, however, that so many applications having been made for copies of the plate, it has been determined that the plate may be purchased by application to the Librarian.

Obituary.

Malcolm McPherson.

Born February 6th, 1879. Died March 30th, 1904.

Malcolm McPherson was the son of John G. McPherson, of Benwell Grange, Newcastle-on-Tyne, and his untimely death from acute nephritis on March 30th has caused the deepest sorrow amongst his relatives and friends. His first school was the Newcastle Royal Grammar School, from which he was removed after a very short time to the North Eastern Counties School, Barnard Castle, where he remained until sent to Cambridge. At Clare College, Cambridge, he made many friends, and established his reputation as a sound man and an excellent sportsman. His career at Guy's was all too short, but he has left behind him a small circle of intimate friends who deplore his loss, to say nothing of the regrets of many who knew him but slightly. In spite of his healthy physique which had scarcely known anything of disease or sickness, he was cut off at the early age of twenty-five. All his friends unite in their expression of sorrow for his bereaved family.

The Relation of Dental Caries to Disease.

By Kenneth Black.

Read before the Physical Society on December 5th, 1903.

Mr. President and Gentlemen,—In this essay I shall endeavour to place before you some of the more important causes of decay of the teeth; and I shall endeavour to show you how these causes may be prevented; and I shall briefly mention some of the more important conditions that may arise from the presence of decayed teeth in the mouth. In a short paper of this nature, it is impossible to more than briefly deal with so wide a subject, and attention will chiefly be devoted to the importance, and close connection, that exists between *prolonged gastric digestion and dental caries.*

In the first place, "dental caries" must be clearly defined. Briefly stated, by "dental caries" is meant the disintegration of the hard tissues of the tooth, commencing at the surface, and extending inwards towards the pulp. Decay can never occur in an unerupted tooth; but a tooth sometimes decays as soon as it erupts through the gum, perhaps leading one to suppose it was decayed before eruption. This is a common error often made with regard to wisdom teeth, as they frequently are found decayed when only partially erupted. The condition of erosion of the teeth that occurs in some cases, and the condition of yellow craggy enamel that occurs in others, claim an entirely different pathology to that of dental caries, and no further mention will be made of them.

A thorough grasp of the cause of dental caries is necessary in order to fully understand the conditions that arise from the presence of diseased teeth in the mouth. The scheme of this paper will be, firstly to consider the local changes that result in the decay of the teeth, and how these changes are produced; secondly, to consider the general and fundamental predisposing cause of dental caries, namely, prolonged gastric digestion; and thirdly, to consider some of the more prominent morbid conditions attributable to decayed teeth.

The local cause of dental caries may be summed up in the expression *acids plus germs.* The acids dissolve the inorganic salts of the tooth, and the bacteria later on, peptonise, that is, make soluble, the collagenous matrix. The presence of acids in the mouth may be accounted for in several ways; they may be directly taken in food or medicine, or they may be eructed from the stomach, or the saliva may become acid, and lastly and most important of all, the carbohydrate food lodged on or between the teeth may undergo acid fermentation from the action of certain micro-organisms normally present in the mouth. It is this last factor which leads to the local dissolution of the tooth substance known as "dental caries." The ptyalin of the saliva acting on the starch or dextrine lodged on or between the teeth results in the formation of sugar, chiefly maltose. The

bacteria now convert this maltose into lactic, acetic and butyric acids, or the bacteria may themselves convert carbohydrate food into acids without the aid of ptyalin. Thus, as a result of lodged carbohydrate food a comparatively concentrated acid is produced, which, if allowed to remain in contact with the enamel of the tooth, will cause its decalcification. Normally, the saliva is alkaline, and any acids produced locally in the crevices of the teeth are at once neutralised and decay prevented. If, however, the saliva does not neutralise these acids the enamel is dissolved, and the dentine exposed; then the bacteria penetrate along the now open dentinal tubules, and, forming more acid, dissolve the inorganic salts of the dentine matrix. Lastly, the organic matrix of the dentine is peptonised and dissolved. Thus caries is developed and the process of dissolution of the tooth continues as long as the acids produced locally are unneutralised; finally the pulp chamber is exposed and the tooth destroyed. The local cause of caries, then, is the acid fermentation of carbohydrate food* lodged on or between the teeth, leading to the destruction of the enamel and the consequent exposure of the dentinal tubules to bacteria.

Although this is the local cause, a little reflection will show that there is some other factor at work which favours this process in the development of caries. This condition of bacteria and lodgment of carbohydrate food is found in the mouths of all animals, domesticated or wild, and in man, civilized or uncivilized, and yet caries is almost unknown in animals and almost unknown in uncivilized man. As to the nature of this other factor, various suggestions have been made. One view is that the early use and cultivation of the brain, at the expense of the nutrition of the body among civilized races, has deprived the developing teeth of the phosphates that are necessary for their proper calcification, leading to poorly calcified teeth, which are then more easily attacked by the acid fermentation of carbohydrate food adhering to them. This suggestion is negatived by the fact that the teeth of civilized man are as highly, if not more highly, calcified as those of prehistoric and uncivilised man and animals. Another suggestion is that the artificial dietary of civilised races causes the teeth to be used very little for the purpose of mastication. Now, the manufacture of many artificial foods tends to the elimination of the fibrous material, which naturally would have a cleansing action on the teeth, for example, in bread the fibrous portion of the wheat is eliminated; thus these prepared foods cling to the teeth more easily. This view, then, infers that by insufficient use and the want of natural cleansing the teeth are prone to decay. This suggestion, like the last, is improbable; on the one hand, some people, whose teeth are never cleaned, have sound teeth, on the other hand, other people, who take the greatest care of their teeth, and whose foodstuffs are similar, are prone to caries.

* Proteid food by the action of organisms in the mouth undergoes putrefaction, with the formation of alkali.

Among the members of uncivilised races caries is rare, even in those races where carbohydrate food preponderates. Some few of these individuals may polish their teeth for the sake of appearance, but certainly with no idea of preventing decay. Among civilised races, where decay is prevalent, the wealthier classes take care of their teeth, the poorer classes do not, and yet caries is not more common among the latter than among the former. It is clear from a consideration of the above facts that the determining or fundamental cause of caries is most likely some condition of the mouth secretions prevalent in civilisation which either favours the growth of the necessary bacteria or fails to neutralise the acids they produce.

We have now to consider whether the *reaction* of the secretions of the mouth has any influence on the growth of the necessary bacteria or not, for saliva possesses no germicidal properties. Generally speaking bacteria flourish and are most active in a medium of a certain alkalinity, varying within considerable limits. The mouth secretions, which are normally alkaline and at the temperature of the body, therefore present a great opportunity for the growth of many bacteria. Many bacteria are destroyed and others become passive in an acid medium; so that, when the contents of the mouth become acid, many bacteria are destroyed whilst others remain passive. Some of the acid-producing bacteria, however, can flourish extremely well in an acid medium; therefore the general reaction in the mouth may not be the factor which determines the growth of the necessary bacteria, as many of the caries-producing bacteria can flourish as well in an acid as in an alkaline medium. On the other hand, it is extremely probably that the reaction in the mouth has considerable influence in determining whether the acids produced by fermentation of lodged carbohydrate food are neutralised or not, for if neutralised by alkali the enamel will not be attacked, but if unneutralised it must be gradually dissolved.

We will now consider the conditions under which the saliva is unable to neutralise the acids produced locally. The saliva under two conditions is unable to neutralise these acids, namely—(1) when deficient in alkalinity, (2) when deficient in quantity.

(1). It is well known that the saliva becomes less alkaline or even acid in any condition of prolonged gastric digestion. It is only necessary to point out that prolonged gastric digestion is found coincidently with nearly all cases of indigestion or dyspepsia, which latter conditions are brought about either by indiscretions of diet or by general states of ill-health, such as occur in anæmia, at the menopause, or during febrile diseases. In fever, moreover, the saliva is less alkaline for another reason, namely—the parotid saliva is less alkaline than either the submaxillary or the sublingual saliva, and the parotid is the only salivary gland at all active during fever. The fever patient is fed on a light diet which requires little or no mastication, thus the submaxillary and sublingual glands remain more or less inactive, as mastication is necessary to stimulate these glands to activity, whereas

the parotid gland secretes saliva without the stimulus of mastication.

(2). The saliva, in common with the other secretions of the body, is deficient in quantity in febrile states.

When the influence of these two main factors co-exists the tendency for the teeth to decay is greatly increased. For instance, the result of fever is that decay progresses rapidly unless the teeth are scrupulously cleansed; the saliva is not only deficient in quantity, but it is deficient in alkalinity, neutral or even acid, for the reasons given above, namely, fever is associated with imperfect and prolonged digestion and fever tends to the secretion of parotid saliva only. It is by no means rare for a patient with typhoid or other prolonged fever, whose mouth is neglected, to have a set of sound teeth completely ruined. It is also common experience for decayed teeth to start aching and give rise to trouble during an attack of fever.

The cause of prolonged gastric digestion among civilized nations is not far to seek. Among civilized women the claims of society, physical or mental work, too often prevent a mother suckling her child. A new-born infant, from improper dieting, rarely ever has a good digestion, and the error in dieting is perhaps the chief cause of infantile mortality. The child is brought up by hand and fed on cow's milk, with generally substances that cannot be properly digested, so irritating the stomach and causing dyspeptic troubles which become chronic. Then, when the teeth erupt, notwithstanding their generally perfect formation, they very soon decay on account of the resultant neutral or acid saliva favouring the production of caries. The teeth, when decayed, further tend to keep up the state of chronic dyspepsia by rendering mastication imperfect. A vicious circle is thus established, the prolonged digestion leads to decay of the teeth, and the decayed teeth tend to maintain the dyspeptic trouble. As the child grows and gets older it will probably be left with an impaired digestion and an irritable stomach, upset by the least error in the dieting. The particular case may be cited in the instance of the adult who, after a late and heavy meal, will awake in the morning with an unpleasant tase in the mouth, due to the acidity of the saliva.

All the known ætiological factors of dental caries, such as the frequency of decay in children, young adults and the aged, especially those of the female sex, and the influence of smoking and pregnancy on decay, are in accordance with the view that prolonged gastric digestion is responsible for the production of caries. These factors have been discussed in a former paper.* Persons with normal gastric digestions, that is, persons who do not overfeed, who do not eat too fast or who do not in other ways abuse their digestions, have sound teeth, unless the teeth have been attacked by a former period of prolonged gastric digestion. In those persons suffering from gastric derangement dental caries is invariably present and progressive, unless the greatest care is taken of the teeth. Some will say they have bad teeth and yet have never suffered from dyspepsia; perhaps so, but if investigation be carefully made, these same individuals will be found to have had prolonged gastric digestion, which is the necessary result of indiscreet dieting or of illness. The mouth condition may, perhaps, be the only sign of the gastric trouble. Just in the same way an individual may never consciously suffer from heart trouble, yet extensive cardiac disease may be present.

The great rarity of dental caries amongst animals is no doubt due to the greater degree of alkalinity of their saliva. Animals have normally a saliva much more alkaline than that of man; and although domesticated animals suffer from indigestion, their saliva probably never wholly loses its alkalinity. It is possible that uncivilised man, who undoubtedly occasionally suffers from dyspepsia, secretes a saliva more alkaline than that of civilised man; this has not been tested, but is a point worthy of investigation. Amongst domesticated dogs indigestion is common, due to improper feeding; especially is this so amongst pet dogs. These pet dogs are largely fed on carbohydrate food, such as sugar, biscuits, etc., and as the typical carnivora have no ptyalin in their saliva, this class of food is never properly digested. Caries is practically unknown, although erosion, which is due to an entirely different cause and which is frequently misnamed "caries," is not uncommon in domesticated dogs. Tartar deposits are common in the dog, and often so excessive that they cause recession of the gums and alveolar processes, with consequent loss of the teeth.

The amount of tartar gives a very good index of the alkalinity of the saliva, as tartar is deposited only when the saliva is alkaline, and the greater its alkalinity, other things being equal, the greater the deposit of tartar. Therefore, when we examine the mouth of a patient and observe a tartar deposit at the necks of the lower teeth, we may safely infer that the subject possesses a saliva for the most part alkaline; and an individual whose saliva is always alkaline possesses a sound digestion.

The process of decay in some persons ceases, and the teeth may remain carious for years without giving trouble. This arrest in the advance of decay has been brought about by an alteration in the reaction of the saliva. The altered condition of the saliva is due to an improvement in the general health of the subject; the subject, who previously had a period of prolonged gastric digestion, which had led to a deficiency in the alkalinity of the saliva, now has an improved digestion with a greater and more or less constant alkalinity of the saliva. When the saliva is continuously alkaline all further process of decalcification of the dentine ceases, for any acids produced by the fermentation of carbohydrate food lodged in the decayed teeth are neutralised. A continuous state of alkaline saliva tends to the precipitation of tartar, which is a substance chiefly composed of the salts of the saliva and deposited in those regions that are bathed continuously with alkaline saliva, namely, at the necks of the lower teeth and in carious lower teeth.

* "Dental Caries," Guy's Gazette, January 19th, 1901.

The care of the teeth and the prevention of decay rests to some extent with the physician, for the aid of the dentist is only sought when the teeth give rise to pain, and pain is often a late symptom of dental caries. How often is the mouth neglected during a fever? It is only of recent years that attention has been paid to the care of the mouth during general disease, and now in hospitals after all abdominal operations, as a routine method, an antiseptic mouth-wash is used. This use of antiseptics in the mouth may with advantage be extended to all hospital in-patients, especially to those suffering from fever or disease in which a diet requiring little or no mastication is necessary, for it is these diseases that are associated with marked prolonged gastric digestion. There are three properties a mouth-wash should possess, it should be antiseptic, *alkaline* and pleasant to taste. Chinosol, used largely at this hospital, is of a disagreeable taste, and on the whole I know of nothing preferable to carbolic acid combined with glycerine and sodium bicarbonate.*

Before leaving this part of my subject allow me to summarise the foregoing observations. Caries occurs when the acids produced by the activity of bacteria on carbohydrate food lodged on or between the teeth are unneutralised. The inability to neutralise these acids that are produced locally is due to an insufficiency in quantity or in alkalinity of the saliva. The chief factor which determines the insufficiency in quantity of the saliva is fever, and the chief factor which determines the insufficiency in alkalinity of the saliva is prolonged gastric digestion. Prolonged gastric digestion is due either to severe illness or to improper dieting, which latter is the result of the unnatural upbringing, the indigestible food, the hasty breakfast and lunch, and the heavy and late dinner prevalent among the more highly civilised nations. The teeth, when decay has *far advanced*, tend to keep up this state of prolonged digestion by rendering mastication imperfect.

Passing from the cause of dental caries to its possible results, it is important to remember that a decayed tooth does not necessarily cause toothache. Extensive caries may exist without pain of any kind, especially if the general health of the patient is good; but it not uncommonly happens that diseased teeth, previously the seat of little or no pain, are prone to ache when the patient's health has become lowered by disease or exhaustion.

Hyperæmia of the pulp is the common cause of toothache. This hyperæmia is due to some irritation, in the vast majority of cases, to the sensitive dentine exposed from caries. The irritation is produced by such agents as acid, sugar, heat, cold, etc., and the amount of pain is roughly proportional to the amount of pulp tissue. Neither dentine nor the tooth pulp are supplied with cold or warm spots, that is to say, no feeling of either cold or warmth can be elicited by touching the dentine or tooth pulp, the only feeling induced being that of pain. The temporary treatment of toothache from this cause, as would be expected, is first to protect the sensitive dentine from external agents, and second to neutralise any acid that may exist in the tooth cavity. A simple and efficient method is to apply an alkaline powder, such as sodium bicarbonate on a pellet of cotton wool It is interesting to note that Sir Dyce Duckworth discovered this simple remedy for the relief of toothache years ago.

Acute inflammation of the pulp occurs when the irritation to the pulp tissue is excessive, and this condition is generally associated with caries that has penetrated into the pulp chamber. Suppuration follows in the majority of instances as the acute effusion causes strangulation of the nutrient vessels entering at the apical foramen; so the pulp becomes gangrenous and easily succumbs to pyogenic infection. The pus escaping at the apical foramen will lead to periodontitis and alveolar abscess. For the treatment of pain from this cause, the mere application of alkaline powder will not be sufficient, a local anæsthetic is necessary, pure carbolic acid on wool being perhaps the most useful. Dental aid, however, should be sought at an early stage.

Chronic inflammation of the pulp arises from the same cause that results in acute inflammation, the irritation, however, being less marked and intermittent; the result of chronic inflammation is that the pulp tissue undergoes a change; in rare instances it overgrows, forming what has been termed "polypus of the pulp"; commonly it degenerates and dies, leaving a gangrenous mass, and this is ever ready to suppurate and form an idiopathic abscess, which may burrow and point in some position far removed from the mouth.

Periodontitis or *dental periostitis*, that is, inflammation of the membrane that surrounds the root of the tooth and lines the bony socket, is generally secondary to inflammation of the dental pulp. The dental periosteum binds the cementum to the bony alveolus, and is continuous at the neck of the tooth with the gum and the periosteum covering the outer side of the alveolar ridge. When inflamed, this membrane becomes swollen; the tooth is raised up in its socket, and tender to pressure; the flow of saliva is increased and the gum around the tooth becomes inflamed from its continuity with the periodontal membrane; the lymphatic glands draining this membrane frequently enlarge, and they may even suppurate. If the process is at all acute, a suppurative periodontitis results, and an alveolar abscess is formed.

Dental or Alveolar Abscess commences, in the majority of cases, at the apex of the root of a carious tooth as a periostitis, secondary to inflammation of the pulp. An effusion of plastic material occurs at the apex of the root of the tooth, around which a little cavity is formed by the absorption of the alveolus, often accompanied by some amount of absorption of the root itself. A portion of this lymph breaks down into pus, and the remainder

* The following prescription may be useful:—

℞. Glycerinum Acidi Carbolici ... ... ℥ss.
Sodii Bicarbonas ... ... ℥ss.
Aquam ad ... ... ℥viii.

Misce.—The mouth wash to be used with an equal quantity of hot water.

forms a fibro-cellular sac around it, just as in the formation of abscess elsewhere; and it occasionally happens that on extracting the peccant tooth the sac and abscess are brought away with it. As soon as pus is actually formed rapid absorption of the surrounding bone takes place and the matter makes for the surface, finding an exit either internally at the side of the tooth or externally by perforating the bony tooth socket and burrowing in the soft tissues. The direction which the pus of an alveolar abscess takes is very variable—the matter may escape through the gum, constituting a gum-boil, or it may find its way on to the face, beneath the chin or into the antrum (this last leads to empyema of the antrum); the pus may track downward along the cellular tissues into the neck, being guided by the cervical fascia; it may point anywhere in the neck, and in some rare instances it has extended into the mediastinum or burrowed into the axilla. There is always more or less cellulitis accompanying an alveolar abscess and this leads to local swelling, heat and redness; when the infection is highly virulent, an acute spreading cellulitis with very little pus formation results, the condition then is often termed "Angina Ludovici." With regard to the treatment of a simple alveolar abscess, the common practice in the front surgery, if the face is at all swollen, is to foment the cheek. Now this habit, handed down from dresser to dresser, is thoroughly bad, for one does not wish a dental abscess to point on the cheek. If the tooth cannot be saved, or means are absent whereby conservative methods might succeed, then the only practice to follow is to remove the tooth, as "better no teeth than septic teeth." Whatever method of treatment is adopted one must never foment the cheek—all fomentation must be done from within the mouth; the patient should be instructed to use a mouth-wash as hot as can be borne, to fill the mouth with it and to hold it as long as it remains hot, then to eject it, and repeat the fomentation as frequently as possible. By this means often the pain and swelling are relieved, and then conservative measures may succeed in saving the tooth, or the abscess may burst through the gum, or, if removal of the foul tooth be effected, the pus wells into the mouth and the evil quickly subsides.

Submaxillary cellulitis, or, as it has been called, "Angina Ludovici" requires special notice, as its pathology is so often misunderstood. It is a disease regarded by the student of medicine as rare, but in the dental department submaxillary cellulitis is by no means uncommon. The site of infection is a decayed tooth in the majority of cases, and the diseased tooth may be unaccompanied by toothache; the infection spreads, periodontitis is the immediate result, and the inflammation extends and involves the cellular tissues. In the most virulent form an acute spreading infective gangrene of the cellular tissues of the neck results, which not infrequently terminates fatally. I have seen two deaths from this disease, and in both cases the teeth were the obvious focus of infection. In the less virulent and more common form the inflammation is more localised; this results in a brawny swelling on the side of the face and neck. In the least virulent and commonest form the process is still more localised, an alveolar abscess is the result, and this is associated with very little cellulitis of the face or neck. The pathology of these conditions is the same, they differ from one another only in the virulence or dose of the infection and the resisting power of the individual. The lesser form may pass into the more severe variety if the source of infection is not dealt with. On prompt radical dental treatment all further spread of the inflammation invariably comes to an end, and the condition quickly subsides; one never sees a case of cellulitis of the neck taken into the general wards from the dental department, and yet these cases frequently occur at the dental out-patients. In the acute varieties the neck and side of the face become swollen, hard and brawny, little or no pus forming; the inflammation quickly spreads along the cellular tissues in those individuals predisposed to the acute speading inflammations; namely—alcoholics, diabetics, etc.: the floor of the mouth, the tongue, the pharynx and the larynx may in turn become involved; the mouth often cannot be opened, the patient may be unable to swallow, and breathing may become difficult. Even at this stage, on promptly extracting the offending tooth, resolution occurs in the vast majority. The danger of a fatal termination is greatest in those persons in whom the cellulitis is rapidly spreading and who do not seek dental aid on account, perhaps, of the condition being erroneously regarded as due to infection from an idiopathic lesion in the floor of the mouth. In these cases valuable time is wasted by a useless attempt to cut short the disease by means of fomentations applied to the face and neck. Death occurs, in the majority of the fatal cases, from septicæmia or from septic bronchopneumonia following tracheotomy.

Necrosis of the jaws occasionally occurs consequent upon inflammation, which most frequently follows tooth extraction. There is a difference in the frequency with which the upper and lower jaws are attacked; the great immunity enjoyed by the upper as compared with the lower jaw is due, no doubt, partly to its less exposed position, but more especially to the fact that necrosis occurs less frequently in cancellous than in compact bone. The great difference in the supply of blood to the two bones must also have an influence, the upper jaw being supplied by numerous branches of the internal maxillary arteries, which inosculate freely from side to side, whilst the lower jaw is supplied by two small branches only. The teeth fit tightly in their bony sockets, and in the extraction of a tooth the bony alveolus is split away by the blades of the forceps; thus, a compound, frequently comminuted, fracture of the alveolus accompanies almost all dental extractions. It is surprising how comparatively seldom necrosis of these bony fragments occurs, considering the septic state most mouths are in that necessitate a radical dental operation. Complete absorption of the alveolus and these bony fragments generally takes place after tooth extraction; this is due to the firm attachment of the gum and periosteum to the bone, and this ensures a good supply of blood under all conditions. When necrosis does occur after extraction it is

generally due to some such cause as multiple extractions, dirty instruments, undue laceration of the gum, ill-health, etc., and the necrosed piece is, in most cases, of small size; it is rare for the whole thickness of the jaw to necrose from this cause.

Phosphorus necrosis of the jaws is a disease due, in all probability, to the tubercle bacillus, the phosphorus fumes acting by strongly predisposing certain individuals to invasion of the jaws by tubercle bacilli. The condition generally is exactly similar to what is seen in tuberculosis of the jaw in cattle, and in tubercular disease of other bones in man. The tubercle bacillus has been demonstrated in a large number of these cases, and the present knowledge goes, at least, to be proof positive of the tuberculous origin of any lesion. Further, in most of the fatal cases of so-called phosphorus necrosis of the jaw, death actually occurs from tuberculosis of the lungs; whether this is due to infection from the jaw tubercle, or to the phosphorus fumes damaging the lungs and so making them more susceptible to direct infection, it is impossible as yet to say. The part which the phosphorus plays in the process is not far to seek; the acid fumes, produced by oxidation of the phosphorus in the air, have no effect on bone covered by gum or mucous membrane, but when they can penetrate to the bone directly through the aperture left by a decayed or extracted tooth or by any injury, they erode the bone, weaken its nutrition and resisting power at this spot, and make it susceptible to infection by tubercle bacilli. The bacilli, frequently present in the mouth, having infected the bone, so-called phosphorus necrosis results, and the necrosis spreads slowly in some cases and with disastrous rapidity in others. The great majority of workers in match factories have carious teeth, and yet only a very small proportion of them become affected with necrosis of the jaw, namely, those who, owing to their home surroundings or to individual predisposition, become readily infected by the tubercle bacillus. There are cases recorded in which the disease started months after the patient ceased working in phosphorus.

Empyema of the antrum is most commonly caused by caries of the upper teeth. Some authorities appear inclined to doubt if dental preponderate in frequency over nasal causes, which latter causes are not uncommonly complications of certain acute specific fevers. It is important to note that the size of the antrum is inconstant; and although disease of the first and second upper molars is the most common causative dental factor of empyema of the antrum, yet, in the case of an exceptionally large cavity, caries of the bicuspid and wisdom teeth and still more rarely of the canines and incisors may lead to a similar result.

Lymphadenitis from septic teeth is very common, especially in children. It is comparatively rare for caries of the upper teeth to give rise to inflammation of the lymphatic glands, although these teeth are frequently decayed, whereas caries of the lower teeth is commonly associated with lymphadenitis. The teeth have lymphatic vessels, yet the pulp tissue is in close communication with the lymphatic system, for coloured particles have been found experimentally to be easily conveyed from the tooth pulp to the lymphatic glands.

Acute lymphadenitis not infrequently occurs in connection with septic lower teeth, and it is associated with more or less periadenitis. In the surgical wards cases now and again occur of abscess in the neck due to the breaking down of an acutely inflamed lymphatic gland; this acute lymphadenitis has been caused in many cases by infection from a foul tooth, the tooth, as often as not, having given rise to no symptoms, such as pain, tenderness, etc. Acute lymphadenitis is less frequently due to infection from the tonsils than from the teeth, for the tonsils more or less effectually prevent infective material entering the lymphatic system as they are themselves composed of lymphoid tissue, and in the struggle to destroy the invader the tonsils themselves frequently suffer and become inflamed. If the acute lymphadenitis is due to a very virulent infection the cellular tissue round about the gland becomes inflamed, constituting a periadenitis; this periadenitis may spread rapidly and produce the form of cellulitis of the neck already referred to and generally termed "Angina Ludovici."

Chronic lymphadenitis is much more common than the acute form, and its importance lies in the fact that such glands frequently become infected with tubercle bacilli. Investigations have shown the close connection that exists in children between dental caries and glandular enlargements. Odenthal examined close on a thousand children and he found decay of the teeth in 50 per cent., and of these 99 per cent. had glandular swellings. Of the remaining 50 per cent. without decayed teeth, glandular swellings were noticed in only 49 per cent. He was also able to establish a constant relation between the extent of the glandular swellings and that of the decay; in such cases where the pulp was exposed—that is, where there was probably a gangrenous or highly inflamed pulp—the swelling of the glands was almost invariably more extended and pronounced; further, the presence of a number of decayed teeth was universally accompanied by very marked glandular swellings; lastly, when there were decayed teeth on both sides of the jaw there were corresponding glandular swellings on both sides. These conclusions have been confirmed, more or less exactly, by other observers.

The submaxillary and cervical lymphatic glands drain the lower teeth; these glands frequently become the seat of tubercular infection when their resisting powers have been lowered from repeated attacks of inflammation, due in most cases to a septic condition of the lower teeth. Whether the tubercle bacilli in these cases gain entrance by the decayed teeth or by some other focus it is difficult as yet to say, but it is certain that tubercle bacilli do, in some cases, infect the lymphatic glands direct from the teeth. The proper treatment and care of the teeth of children and the prevention of decay should render chronic glandular enlargements in the

neck, whether the result of tubercle bacilli or not, a much less frequent condition than exists at the present day.

Actinomycosis may be incidentally mentioned. It is a rare disease, the actinomyces gaining entrance to the system generally through a decayed tooth.

Tonsillitis, one of the pyogenic infections in the buccal cavity, possesses a long list of possible causes; namely—overwork, worry, rheumatism, sudden changes of temperature, bad drainage, etc., every conceivable factor is noted, but no mention is made of a source of infection far more common, namely—dental caries. Dental caries is often associated with a septic condition of the gums, which are adjacent to the tonsil themselves. The omission to recognise this possible source of infection, is the more remarkable, as the tonsils are more and more being recognised as themselves, possible channels of general infection. Furthermore, decayed teeth greatly favour the growth of organisms, as they form excellent protected receptacles in which food may remain undisturbed; thus septic and other organisms are constantly being swallowed. Although it has been shown that in gargling with coloured solutions the tonsils are not touched, yet they must run a great risk of being infected, as material pregnant with organisms must flow past them if the teeth are decayed. If the mouths of persons suffering from tonsillitis be examined, it will be found that in quite a large number the teeth are decayed. We have then two means by which decayed teeth may lead to tonsillitis, one is by the direct spread to the tonsils of the inflammation of the gum surrounding the tooth, the other is by some of the infective material from the teeth settling on the tonsils during the act of swallowing.

Neuralgia of the trigeminal nerve is, in the majority of cases, due to irritation of the termination of the dental branches, and of the teeth, the lower wisdom most frequently are at fault in its production. A careful and thorough examination of the mouth should, in every case of trigeminal neuralgia, be made; a tooth, apparently sound, may have a minute undetected cavity that may be the cause of severe neuralgia, or an unerupted tooth, or one that has been filled, may be the source of irritation leading to referred pain. It is a sound rule in every case of neuralgia of the fifth cranial nerve without obvious cause, that persists in spite of treatment, to send the patient to a dentist for a thorough examination of the teeth.

Trismus, or spasmodic closure of the jaws, is the commonest variety of muscular spasm due to a dental cause. It may be of short duration or it may last several weeks, and it is generally connected with the eruption of a wisdom tooth of the lower jaw. Owing to want of room between the second molar and the ramus of the mandible, or owing to some malposition of the tooth itself, the wisdom tooth is unable to assume its normal position, and, by the pressure which it exerts on the neighbouring structures, sets up irritation, which induces a state of tonic spasm of the masseter and internal pterygoid muscles. The majority of these cases occur about the age of twenty, when the eruption of the wisdom teeth is to be expected, and the diagonsis is readily made. Some cases of trismus are due not to erupting but to decayed teeth, especially to irritation of the pulps of the molars. The treatment of this condition is obvious, the mouth must be forcibly opened under an anæsthetic, and the impacted or decayed tooth, as the case may be, removed.

Besides trismus there are other forms of muscular spasm of dental origin, but it appears doubtful whether paresis or paralysis is ever due to the same cause. Cases of tonic cramp of the upper extremities, of the neck and face from irritation of a tooth pulp are recorded; some of these cases have suggested tetanus, and the correct diagnosis has been determined only when some particular tooth was extracted.

General disease and oral sepsis. As reference has already been made to the more common local conditions that may arise from decayed teeth, this brief essay can be concluded by a few remarks on oral sepsis in relation to general disease.

Firstly, we will briefly mention the relation of dental caries to *pyæmia* and *septicæmic* conditions. Most are agreed that decayed teeth are a possible source of general infection as pyogenic cocci are present in every case of dental caries. There seem to be undoubted cases of acute infective osteomyelitis, infective endocarditis, empyema, meningitis, septicæmia, and possibly tetanus where the primary source of infection was from a decayed tooth.

Lastly, we will consider the relation between dental caries and *sapræmic* and *toxæmic* conditions. When roots and decayed teeth exist in the mouth and lead to continual suppuration of the adjacent gum, the decay of these roots and teeth does not progress on account of the constant presence of alkaline pus; this pus neutralises any acids produced by micro-organisms acting on lodged carbohydrate food. Foul roots and teeth, therefore, exist sometimes for years, a constant source of irritation to the surrounding parts, leading to constant suppuration of the adjacent tissues in some and to precancerous conditions in others. Dr. William Hunter has most ably pointed out the great importance of careful attention to the mouth; he believes that many states of ill-health are due entirely to oral sepsis, originating, in the majority of instances, from dental caries and pyorrhœa alveolaris (this latter is a disease the pathology of which is at present undetermined). He cites cases of dyspepsia, anæmia, debility, etc., where the thorough treatment of the mouth condition led to a return to good health. I am inclined to regard Dr. Hunter's views as extreme, for the majority of cases of oral sepsis are due to the same cause as that which produces ill-health, namely, prolonged gastric digestion. No doubt, when once the teeth have become badly decayed they assist and tend to keep up the state of ill-health, partly from the inability of the individual to thoroughly masticate and partly from the swallowing and absorption of septic material; so the treatment of the mouth condition in these cases is bound to result in more or less improvement in the general health.

With regard to the *anæmias* that occur in children and young women, there is little evidence to support the view that they are due to septic absorption secondary to oral sepsis; one frequently sees a chlorotic girl with perfectly sound teeth. In a series of articles which appeared in the *Lancet* a year or two ago Dr. Hunter deals fully with the disease termed "pernicious anæmia." He finds that this disease is frequently associated with a septic condition of the mouth, and he inclines to the view that the oral sepsis is the chief factor in its production. This seems a doubtful point, for oral sepsis is remarkably common, yet pernicious anæmia is comparatively very rare; further, in some cases of pernicious anæmia, oral sepsis has been absent, whilst in other cases the extraction of all the foul teeth has led to little or no improvement in the general health of the patient. We have, then, two different sets of diseases termed "anæmias" that have been attributed to oral sepsis; the one set, including chlorosis, is associated with a diminished formation of, especially, the red corpuscles; the other set, including pernicious anæmia, is associated with a blood destruction.

The close connection that exists between gastric affections and oral sepsis is undoubted, but all authorities have attributed the gastric as secondary to the oral condition, whereas I maintain that the oral condition is secondary to gastric derangement, which latter has not necessarily given rise to symptoms of pain, nausea, vomiting, etc. The only evidence of the gastric derangement (delayed peptic digestion) is often limited to the morbid conditions existing in the mouth. Just as a systematic examination of the urine gives a very good idea of the state of the kidneys, so an examination of the teeth, gums and saliva will give a reliable index of the state of the digestion. This is a fact not yet realised by the student of medicine, and it is hoped in the future, more attention will be paid to the oral condition as a means of diagnosis.

The start of the many derangements connected with the alimentary tract, including dental caries, tonsillitis, gastro-enteritis, migraine, biliousness and possibly appendicitis, is to be found in prolonged gastric digestion. The main point in the general treatment of these many conditions is the same, namely—purgation, which rids the alimentary canal of the irritating and undigested food. There is no truer saying than that "the stomach governs the world." At birth we are usually in possession of healthy digestive organs, civilisation abuses them, and derangements follow; thus in infants, long before the dental organs are formed, diarrhœa, vomiting, colic and wasting prevail; these gastric derangements lead in some to death and in others to a feebleness and lowered vitality that predisposes them to contagion and disease. Nature provides us with *two* sets of, in most cases, perfectly developed teeth, but from the already existing digestive trouble they very soon decay, the process of decay being hastened in the same way by any fever that we may contract. Authorities claim that the fault lies in our teeth and not in our stomachs, for they observe that on correcting the oral sepsis improvement follows; this improvement, however, is generally only temporary, and finally at an early age, the false teeth replace nature's second set. Perhaps no more striking example of the abuse of the digestion can be found than the frequency with which rickets occurs; rickets is a disease met with amongst badly-fed children, and here the teeth erupt late and soon decay. The opinion of one of the coroners of Philadelphia was that fifty per cent. of all children's deaths coming under his observation were due to oral sepsis; this coroner, no doubt, had he investigated further, would have found that a hundred per cent. of these children who "died of oral sepsis" had had gastric derangement (prolonged peptic digestion) from birth.

A healthy digestion leads to a sound body and mind. An unhealthy digestion leads to an unhealthy body, which may end in an unhealthy mind. Civilisation is responsible for the artificial feeding of infants and the improper dieting of adults, namely, the late and heavy dinner, the indigestible supper, and the hasty breakfast and lunch. The immediate result of this abuse of the digestive organs is prolonged gastric digestion, then dental caries follows and with it a whole train of possible evils. It is important therefore to prevent prolonged gastric digestion, which I maintain is the fundamental factor in the production of decay of the teeth.

Guy's Hospital Children's Christmas Tea Fund.

DECEMBER 31st, 1903.

Receipts.	£	s.	d.
To Balance brought forward	45	14	4
„ Subscriptions	109	1	3
„ Collection from Hospital Workmen ...	2	4	7
	£157	0	2

Expenditure.	£	s.	d.	£	s.	d.
By cost of Tea and Refreshments	34	15	5			
„ Gifts of Toys, &c.	15	16	5			
„ Cinematograph Expenses ...	6	16	0			
„ Printing, Stationery & Postage	3	7	1			
„ Fees to Servants and Police ...	5	4	0			
„ Hiring and Sundry Expenses .	2	16	11			
				68	15	10
„ Special Donations:—						
Guy's Hospital (to maintain a Cot)	25	0	0			
The Haven	15	0	0			
Maternity Samaritan Fund .	10	0	0			
Out-Patient Visitor	5	0	0			
				55	0	0
„ Balance carried forward:—						
Reserve on Deposit	30	0	0			
Cash at Bankers	3	4	4			
				33	4	4
				£157	0	2

Audited and found correct,

April 15th, 1904. CHAS. H. WELLS.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. J. M. Barrionuevo (Dr. Taylor); A. V. Maybury (Dr. Hale White); G. C. F. Robinson (Dr. Pitt); F. W. Morton Palmer (Sir Cooper Perry).

Ophthalmic Dressers.—Messrs. D. Isaacs (Mr. Higgens) (May 1st); E. C. Myott (Mr. Brailey) (May 1st).

Surgeons' Dressers.—Messrs. C. W. R. Preston, R. S. Harper, T. Norman, M. Leckie, H. F. Wight, E. F. Milton (Mr. Lucas); J. E. Scales, T. C. Pocock, E. E. Rendle, F. A. Sharpe, B. B. Metcalfe, R. J. Bentley (Mr. Golding Bird); H. C. Cameron, V. A. P. Costobadie, G. W. Nicholson, E. Bellingham Smith, H. A. Watney, E. H. Adams (Mr. Jacobson); A. H. Miller, G. H. K. MacAlister, F. T. H. Wood, H. S. Knight, W. P. Purdom, G. Hamilton (Mr. Symonds).

Externs.—E. White, H. P. Costobadie, R. P. Lewis, W. C. McM. Dickey, R. D. Barron, A. B. O'Brien (May); J. A. C. Greene, G. F. Greening, A. D. Crofts (June); R. O. Williams, R. A. Chisolm, I. R. Cook, T. Turner (July).

Civil.

Evans, George, M.B. Lond., M.R.C.S., L.R.C.P., has been appointed Assistant Medical Officer to the Heath Asylum, Bexley, Kent.

Naval and Military.

Fleet Surgeon W. Bett, R.N., has been appointed to H.M.S. *Russell*.

Surgeons H. G. T. Major, R.N., and F. M. Vincent Smith, R.N., have been appointed to the *Bulwark* and *Fire Queen* respectively.

The undermentioned gentlemen have been appointed dental surgeons to the troops from April 1st, 1904, and posted to the stations opposite their names:—

J. K. Clark, L.D.S. Eng.	...	Aldershot.
A. F. A. Howe, L.D.S. Eng.	...	Portsmouth.
C. W. Randall, L.D.S. Eng.	...	Colchester.

The terms of contract for these appointments are precisely similar to those for civilian surgeons. Pay is £1 a day with travelling expenses extra. The number of candidates for the eight appointments sanctioned for the army was considerably over 100.

The late Frederick Charles Stearn, Surgeon, R.N.

The funeral of Surgeon F. C. Stearn, R.N., one of the medical officers of Portsmouth Dockyard, took place on April 6th, with full naval honours. The service in the Dockyard church was held by the Rev. Dr. Shone, and was attended by Rear-Admiral Henderson and all the dockyard officers, Flag-Captain Sir R. K. Arbuthnot representing the Commander-in-Chief. Afterwards a procession was formed headed by a firing party. Then came the band of the Royal Naval Barracks, preceded by a field gun carriage, on which was the coffin covered with a Union Jack and bearing the deceased officer's hat and sword. Six surgeons were pall-bearers. Carriages with private mourners followed, and after them walked a large number of naval and dockyard officers. The interment was at the Highland Road Cemetery, and at the close of the service the usual three volleys were fired over the grave.—*Lancet*.

Births.

CLAYTON.—On April 9th, at Willesden Green, N., the wife of Edward Clayton, L.D.S. Eng., of a daughter.

FAGGE.—On April 6th, at St. Thomas's Street, London Bridge, S.E., the wife of C. H. Fagge, M.S., F.R.C.S., of a daughter.

WALKER.—On April 13th, at 14, Odos Lycabetes, Athens, the wife of A. W. Walker, L.D.S. Eng., of a son.

Marriages.

ANDERSON—BROWN.—On April 14th, at All Saints, Boyn Hill, Maidenhead, Kenneth Anderson, M.B. Lond., M.R.C.S., L.R.C.P., of Banwell, Somerset, to Dorothy Mary Sneade, eldest daughter of the late Rev. J. H. Brown, of Bedstone, Shropshire, and of Mrs. Brown, of Heartsease, Boyn Hill, Maidenhead.

FAWSSETT—WILLIAMS.—On April 21st, at St. Cuthbert's, Philbeach Gardens, S.W., by the Very Rev. Dean Randall, Francis William Fawssett, M.B. Lond., M.R.C.S., L.R.C.P., of 228, Fore Street, Edmonton, to Mildred Evelyne, third daughter of the Rev. E. P. Williams, of 24, Philbeach Gardens, S.W.

HOLLIST—HODGSON.—On April 7th, at St. Margaret's, Lee, Kent, by the Rev. Canon Jelf, of St. German's, Blackheath, and the Rev. W. Sidney Randall, C.F., Gerald Wetherell Capron Hollist, M.R.C.S., etc,, second son of Lieutenant-Colonel Hollist, D.L., J.P., of Lodsworth, Petworth, Sussex, to Ruby, twin daughter of Nevil L. Hodgson, Esq., of Woolwich and Blackheath.

TIPPING—COOPER.—On April 20th, at St. Iltyd's, Ilston, by the Rev. Voel Roberts, Vicar, Harold Tipping, M.B. Lond., M.R.C.S., L.R.C.P., youngest son of T. J. W. Tipping, Esq., of Upper Clapton, to Florence, youngest daughter of the late D. Cooper, Esq., of Carmarthen.

Death.

GOWING.—On April 10th, Benjamin Chaston Gowing, M.R.C.S., 1865, L.S.A., 1866, Guy's Hospital, late President of the Southern Branch, British Medical Association, practising at Stockbridge for the past eleven years.

MORICE.—On February 20th, 1904, at Greymouth, New Zealand, Charles Lloyd Morice, M.R.C.S., L.S.A., aged 70.

Ed.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 418.] MAY 7, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	181–183
Discharge from the Ear. Clinical lecture by Mr. Higgens	184–189
With Dr. Shaw in Medical Out-Patients ...	189–191
Pass List	191
In Lighter Vein	192
Correspondence	193–195
A Case of Depressed Fracture. Fractured Base. Operation. Recovery. No Sequelæ	195
Hospital Ideals—A Nightmare	196
Notes from Skin Outers	197
Real Conversations	198–199
Papers by Guy's Men	199

Passim.

AT last in the park the "reviving herb" tells us that Spring is with us in earnest, and the assiduous attention to the grass on the part of one or two worthies, who are, alas, engaged in assisting nature, reminds us of the coming joys of Prize Day and other tender recreations peculiar to the Summer Session. There are no such stirring events in store for us this summer as there were last, in fact, there promises to be a dearth in excitement—but if a good hot summer is forthcoming, even the most gregarious amongst us will be content to dispense with crowded humanity.

WITH the advent of May we have been taught to look for the Freshman, and once again he has not disappointed us. It stands to reason that he is to be congratulated on his choice of the best of all possible hospitals, and if he is willing to accept the responsibility of his position in the same, he will be welcomed as a man and a brother. Should his eye chance to light upon this page, he will be relieved to hear that this is not the festive season of the year at which this journal blossoms forth as a guide, philosopher, and friend of youth. This doubtful literary feat is accomplished in October, and, if he possess his soul in patience until that time, he will be instructed most specifically in the way he should go that when he is older he may depart from it. It is interesting to notice that other hospital magazines are not so considerate, and that one in particular has taken the trouble to go over the ground exhaustively for Freshmen. One of the injunctions laid down reads as follows:—"Do not slink about the hospital as if the eyes of all were upon you—you are not yet so important as that. But pluck up heart and walk about boldly as if the whole place were yours; in a short space of time this attitude will become natural." Now, be it distinctly understood, this advice does not hold good at Guy's, and to follow it would inevitably be to court disaster. At Guy's all that is necessary is for Freshmen to walk like ordinary human beings, whatever methods of progression may hold good elsewhere.

WE have great pleasure in calling attention to a letter from Sir Samuel Wilks that will be found in our correspondence column.

After months of expectation the two new theatres are at last in working order, to the great satisfaction of all concerned. There is nothing in the soberer of the two rooms that calls for any particular comment, but the case is different with its somewhat remarkable neighbour, within the walls and under the ceiling of which mere existence becomes a burden. Patiently to submit to such a wholesale reflection necessitates, either that one shall be possessed of a sound constitution and a conscience void of offence, or failing these, that one shall be so deeply interested in the operation as to prevent any undue consciousness of the insistence of the mirrors upon one's own hated lineaments. It is dreadful to think of the effect that this may have in the dog-days upon the indolent ward clerk, and it will be but common humanity to let this gentleman choose between standing in the full glare of the plate glass, and sitting comfortably enough in the mackintosh room from which he can easily be summoned by a simple shout through the gap in the wall. The position of the sister, alone honoured among women by admittance into this surgical holy of holies, is an unenviable one, for while her duties demand her undivided attention there will always be some tendency to personally endorse the enthusiasm of the mirrors. Bacteria will also find a happy home in the line of junction between the brass frames and their plate glass contents, and upon the wood of the ceiling; but perhaps a too great insistence on these is to be hypercritical to a greater degree than the occasion demands.

We are requested to state that Princess Christian has promised to preside over the Annual General Meeting of the Guy's Hospital Ladies' Association, which will be held in the Court Room on Saturday, May 28th, at 4 p.m.

The following letter, addressed to "The Governors of Guy's Hospital" calls for some comment. It refers to the disturbance that took place at the Avenue Theatre on Saturday evening last (April 30th) on the occasion of the performance of "An Artist's Model" by an amateur company in aid of St. Mary's Hospital:–

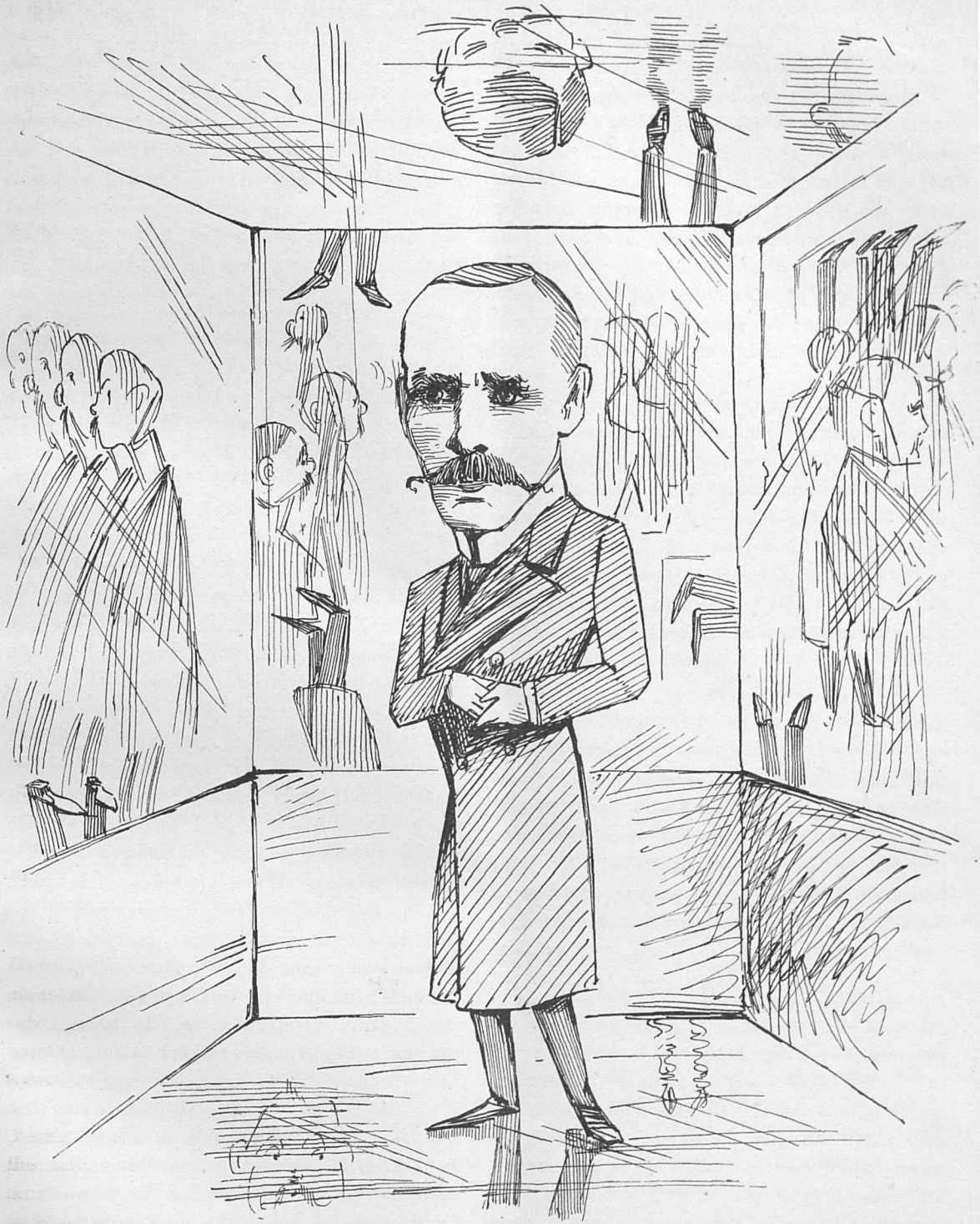
"2nd May, 1904.

"Surely it is impossible for students of any hospital to behave in the manner that was attributed to them on Saturday evening at 'The Avenue.' The roar and racquet commenced a quarter of an hour before the curtain rose and continued to the end of the performance, evidently to frighten and disconcert the performers, and thus to make possible this morning's criticisms. If, instead, it was the intervention of a 'paid opposition,' then the *slur* on all hospital students should be quickly removed" (sic).

H.—— J.——

We have not the pleasure of the acquaintance of the writer of this letter, but from enquiries it would seem that he was one of the unfortunate performers on this regrettable occasion. All will feel sorry that the papers should have visited the sins of the gallery upon the luckless company, but, at the same time, that does not excuse the above hint at "paid opposition" on the part of students of other hospitals not concerned in the venture. Careful enquiries have elicited the fact that the gallery on that night, from which most of the commotion proceeded, was entirely filled by students from a hospital other than Guy's. We agree that these "gentlemen" should have known better, and accept H—— J——'s apologies to us in anticipation.

On May 31st the Debating Society's Annual Dinner will be held in the College. The chair is to be taken by the President, Dr. Savage, who has also consented to indulge in "Reminiscences of General Practice." All those who were present at this dinner last year will realise that this is an occasion that should not be missed, and we have no doubt that the Dining Hall will be again packed to overflowing. At a time when "General Practice" is being discussed so ably in our columns we have no doubt that Dr. Savage's Reminiscences will supply the



REFLECTIONS.

"It must be that. Don't you think so?"

[The two new Operating Theatres are now in use, one of them is remarkable for the plate glass on the walls and ceiling.]

necessary touch of comedy to an otherwise tragic business. Tickets for the dinner can be obtained from Messrs. Watney and Stebbing, the hon. secretaries of the Debating Society. Last year there was considerable difficulty in the seating of the company, and as it is highly likely that history will repeat itself, those who intend dining are advised to secure their seats early.

Arrangements are being made for another massage class to be held during the present session. Mr. Ormond desires that the names of those who wish to join this class may be sent in to him as soon as possible, that the course may start without delay. There will be no other course after this until October.

In the nursing world there are great searchings of hearts, and this month's *Nineteenth Century* contains an article which ably states the case against Registration of Nurses. It must be fairly obvious, however, that this reform is certain to come sooner or later, and instead of warring against the inevitable, it would be better so to organize affairs that the innovation may not strike so hardly at existing institutions. There would certainly seem to be some danger of the personal element in nursing suffering at the hands of a system of mechanical registration, but if this danger is realized beforehand, that will be a very large step in the direction of averting the same. The obvious moral is that nurses of the several institutions must have as much experience as possible, and that theory must in no way take the place of practice in any branch of their work.

The decision of the authorities to break the six months appointment of medical ward clerk into two appointments of three months each, with an intervening three months as assistant surgeon's dresser, is an innovation that will be met with a general chorus of approval. Under the present system, unless a man is fortunate enough to get non-compulsory appointments in the medical wards just previous to his examinations, he is heavily handicapped in the clinical part of the same. It will now be the rule for assistant surgeon's dressers to keep up more than a bowing acquaintance with medicine, by attendance at medical out-patients, thereby adding another three months to their medical clinical experience, which will also terminate later in the curriculum than it hitherto has done.

The Dental entry this May is larger than it has been for the last four years. This is due in all probability to the new regulations which compel candidates for the L.D.S. to pass in Part I. (General Subjects) before they can be examined in Part II. (Special Subjects). The excellent results obtained of late in Part I. has no doubt determined the present increase in the number of the entry.

Messrs. Traill, O'Brien, McEvedy, Morgan and McSaunders, who are to play for the English Rugby Team in Australia and New Zealand, sail on May 11th, and they will carry with them the good wishes of all Guy's men. We have been honoured in the selection of so many players from our ranks, and shall follow the fortunes of the team with the greatest interest.

The Cricket prospects for the coming season get worse and worse. Up to the present there are very few signs of new blood, and the test matches promise to be mere farces. It is difficult to believe that all the available men are to hand. On the contrary, it seems only too likely that slackness is at the bottom of the whole business. In any case the Cup is preparing to take unto itself wings, and we shall thoroughly deserve any reverses that may overtake us in the cricket field.

Discharge from the Eyes.

CLINICAL LECTURE BY MR. HIGGENS.

October 19th, 1903.

GENTLEMEN,—Discharge from the eyes of mucus, muco-pus or pus, means some form of ophthalmia (or, if you like, conjunctivitis), or inflammation, acute or chronic, of the lachrymal sac.

Forms of ophthalmia:—

Catarrhal.
Muco-purulent.
Purulent simple.
" gonorrhœal.
Occurring in newly-born children (ophthalmia neonatorum), or older persons.
Granular trachoma.
Chronic.
Phlyctenular.
Strumous.
Membranous.
Diphtheritic.

The symptoms of conjunctivitis are smarting, pricking, or gritty (often described as sandy) feeling in the eyes, some watering, later on stiffness with increasing discomfort, but hardly pain, and discharge; complaint that the lids are stuck together on waking; in some cases intolerance of light when first the eyes are opened, which passes off later in the day; and increased vascularity. Note well the position of the vessels when the eye is seen to be unduly vascular, as increased vascularity, though one of the symptoms of conjunctivitis occurs in inflammation of other structures of the eye-ball.

The vessels seen in the inflamed conjunctiva form a light red network; they are largest away from the cornea, taper off as they approach it, and end before quite reaching its margin; they are, moreover, easily movable over the surface of the sclerotic. In inflammation of the deeper parts of the eyeball, iris and ciliary body, the vascularity is most marked in a zone around the cornea known as the ciliary region; the vessels are straight, parallel, or nearly so, and quite close together.

The above symptoms are common to all forms of ophthalmia; there are signs by which we can distinguish the various forms from each other. We will now take them more in detail.

Catarrhal ophthalmia may be looked upon as the type of an acute conjunctivitis; it generally arises from atmospheric conditions, is very prevalent in damp cold weather, and an attack is often set up by exposure to draughts; like all other forms, it is contagious, and it is not uncommon to see a whole family, especially among the poorer classes, suffering from the disease. Catarrhal ophthalmia sometimes occurs as an epidemic in public schools, a large number of the boys being attacked by it. Both eyes are almost always affected, but do not, as a rule, begin quite at the same time, there being twelve to forty-eight hours interval from the time the first eye is attacked until its fellow follows suit. The symptoms I have just enumerated are all present in catarrhal ophthalmia and there need be no others; but in typical cases we notice blood extravasation in the ocular conjunctiva and in some the discharge may be so profuse, and so yellow in colour, that it is not easy to say whether the case is one of severe catarrhal or mild purulent ophthalmia. Catarrhal ophthalmia, if left alone, remains in an acute condition for about ten days, then begins to subside and gets well in the course of two or three weeks, or it passes into a chronic condition which may last for weeks. Its course is much influenced by treatment.

Muco-purulent ophthalmia occurs in children. It is characterised by muco-purulent discharge, a good deal of lachrymation and much intolerance of light; the cornea will often be found to be ulcerated and in some severe cases sloughing.

Purulent ophthalmia commences in much the same way as catarrhal, but in the course of 48 hours from the start the difference between the two begins to show itself. Instead of simple congestion of the conjunctiva, and a mucous or, at the worst, slightly purulent looking or blood-stained discharge, the ocular conjunctiva gets bright or dusky red and swollen, and thick and profuse greenish yellow discharge is seen issuing from between the swollen and often discoloured lids. The amount of swelling and discharge varies with the severity of the disease; in the milder cases both are only moderate and soon begin to subside under proper treatment, but in the severe and especially the gonorrhœal cases, the ocular conjunctiva becomes so swollen that it overlaps the cornea (chemosis), the fornix or retro-tarsal fold becomes converted into a red swollen mass which protrudes between the dusky red and greatly swollen lids, and the discharge becomes most profuse; later the tissues may become quite hard and brawny from inflammatory infiltration, the vessels blocked, the nutrition of the cornea interfered with, and

ulceration or sloughing leading to permanent damage or complete loss of sight, take place.

The causes of purulent ophthalmia in patients other than infants are not always very apparent, but in the majority of instances it no doubt arises from contagion, and the most severe cases are those caused by direct inoculation with gonorrhœal discharge, often described as gonorrhœal ophthalmia; but remember that though gonorrhœal ophthalmia is purulent, all purulent ophthalmia is not gonorrhœal.

Always, if possible, ascertain if the patient is suffering from gonorrhœa, and in females whether there is any kind of vaginal discharge, or if in either sex there has been any possibility of contact with another case of ophthalmia or discharge of any kind from a mucous surface, urethral, vaginal or otherwise.

It not infrequently happens that outbreaks affecting a number of individuals occur in communities such as large pauper schools or workhouses, and are doubtless due to contagion from using the same towels and washing in the same water. Sometimes inoculation takes place in most curious ways, or its source may be entirely unsuspected both by the patient's friends and medical attendant.

EXAMPLES.

I have seen a man with purulent ophthalmia who told me that his eyes were rather sore and he thought a little urine was a good lotion; he had accordingly used some of doubtful origin, for he said he had taken it from a chamber utensil used by several different men; the result of his treatment was that he lost both eyes.

In the case of a little girl with severe gonorrhœal ophthalmia I discovered that she had been sleeping with a nursemaid whose conduct had not been as correct as could be wished.

In the case of a young lady whom I was called to see in consultation, said to be suffering from catarrho-rheumatic ophthalmia—a disease with which I am not acquainted—I at once recognised severe gonorrhœal ophthalmia. She lost her eyes. I subsequently had a private interview with her and on putting a few leading questions to her found that she had a vaginal discharge, which was undoubtedly gonorrhœal. She thought she must have inoculated her eye in her bath. Neither her relations or her medical man had the least idea of her condition. I did not give her away.

I mention these cases because I do not wish any of you to be put off your diagnosis for want of evidence of a cause of infection.

Purulent ophthalmia is met with most frequently as *ophthalmia neonatorum*, commencing in newly-born children a few days after birth. The first symptoms are lachrymation and unwillingness on the part of the child to open its eyes, with slight injection of the conjunctiva, then some purulent discharge and slight puffiness of the lids. Mild cases need go no further than this stage, but in the majority the lids soon begin to swell, are firmly closed, and if pulled open the characteristic greenish yellow purulent discharge escapes from between them. The swelling of the lids increases, they become dusky red on the surface, and the discharge becomes very profuse, and may be bloodstained. On separating the lids, which is done with difficulty, it gushes out from between them and a red and swollen fold of conjunctiva may protrude. If we wipe away the discharge we shall often find that some flakes adhere to the conjunctiva, on removal of which a bleeding surface is exposed. We should always, if possible, carefully examine the cornea, as its condition materially influences the prognosis with regard to sight; if it is clear and bright we may form a favourable opinion, but if dull or ulcerated we may be sure that more or less damage will be done, the amount of damage depending upon the extent to which the ulceration goes. It may be only superficial and leave a corneal nebula, or if deeper, a more dense opacity, but if perforation takes place an opacity with adherent iris (adherent leucoma) will result; often the anterior pole of the lens may become affected through the cornea without perforation taking place, a white spot being left upon it constituting what is known as a capsular or pyramidal cataract. In the worst cases the cornea ulcerates or sloughs wholesale, the greater part of it disappearing and its former site being occupied by the bulged forward iris forming a "staphyloma," in such a case sight is entirely lost; later, cicatrisation takes place and a white unsightly bulging is left.

The cause of purulent ophthalmia in infants is undoubtedly in many cases contact with unhealthy vaginal secretions during birth, the worst cases being caused by gonorrhœal discharge; but there remains a large number which cannot be so accounted for and which are probably due to want of care and cleanliness immediately after birth.

We come now to *granular ophthalmia* or *trachoma*, as it is sometimes called, which is caused, in the first place, by constant and prolonged irritation of the conjunctiva from dust and dirt, bad air and general uncleanliness; it

is the curse of some sections of the poorer classes, notably of the London Irish, also of the large pauper schools in this country, and abroad is very common where there is much dust and where the population are careless about their eyes, as in Egypt. It is also very prevalent in Australia and South Africa, from which countries some of the worst casse I have seen have come. It is, moreover, the bane of the ophthalmic surgeon's existence from the difficulty in preventing its occurrence and its extreme rebelliousness to treatment, and Life, from his point of view would be happier without trachoma.

Symptoms.—Those of conjunctivitis. Examination reveals the nature of the disease; the ocular conjunctiva is congested but not intensely; it is upon the palpebral portion that the characteristic signs are noticed. On drawing down the lower lid, its conjunctival surface will be found rough and studded thickly with small spherical bodies resembling sago grains and known as follicular granulations. On everting the upper lid its inner surface will be seen to be rough and vascular looking, like coarse red sand-paper, and like the lower lid, studded with sago grains; these changes are more marked away from the margin and most of all over the attached border of the tarsal cartilage, which causes the bulge seen when the lid is everted.

In cases of long standing, the sago grains will have run together, forming gelatinous-looking masses with depressions between them, the whole having a roughly furrowed appearance, especially along the everted tarsal cartilage border.

Three varieties of granulation are described. The first, in which the sago grains predominate, is called follicular granulation. This is the earliest form in which the disease makes its appearance, and indeed, the sago grains, which are said to be enlarged trachoma glands, may exist for any length of time without causing symptoms, but they are very likely to become inflamed. Persons in whose lids they exist, are said to be predisposed to granular ophthalmia. The second, which is marked by the red sand paper appearance, is known as papillary granulation, and the third, which is a mixture of the two, as mixed granulation. Granular ophthalmia commencing either as follicular or papillary, as time goes on, becomes converted into the mixed form, which is what we most frequently meet with in hospital practice. The appearance of the conjunctival surface of the lid becomes altered by time and treatment. In old cases it becomes smoothed down and scarred, white bands and lines dividing up red and somewhat rough patches.

The discharge in granular ophthalmia, unless some acute form of conjunctivitis gets implanted on it, is not profuse, and consists of flaky mucus, which gets formed into rolls or strings in the fornix, and a good deal of lachrymal secretion. In old cases the conjunctiva becomes altered in structure, shrunken, and its secreting power much diminished.

Changes in the cornea are very common; from constant irritation by the rough surface of the lids, especially of the upper one, it becomes cloudy and vascular, to such an extent in some cases that it looks as if covered by a fleshy growth. This condition is known as pannus and must be distinguished from other forms of corneal opacity. You will see that the opacity is obviously on the surface of the cornea and not in its substance, and that the blood-vessels pass from the conjunctiva to be distributed over the corneal surface In other cases where the cornea has become vascular (with rare exceptions) the vessels are wholly in the cornea, small, and placed very closely together, so closely that the separate vessels can barely be distinguished, the appearance being more that of a blood stain than a collection of separate vessels. The shrinking of the conjunctiva may cause distortion of the lids, or displacement of the hair follicles of the lashes, the result being that some of the lashes turn inwards (trichiasis), or the whole row in one or both lids may be rolled in (entropion); in either case, the cornea is constantly scrubbed by the lashes, and suffers in consequence.

Ulceration of the cornea is by no means an uncommon result of granular ophthalmia. The ulcers may be superficial and get well, leaving only slight nebulæ, or they may go deeply into the substance of the cornea, leaving dense opacities, or they may perforate, leaving either a dense cicatrix to which the iris is adherent, or if the perforation is large, a staphyloma may form. In the former cases, the sight will be more or less permanently damaged; in the last it may be lost. Iritis, more or less severe, frequently occurs in the course of granular ophthalmia.

Chronic ophthalmia is often the remainder of one of the more acute forms, catarrhal or purulent; but may come on gradually without any acute stage.

The eyes feel and look sore, the conjunctiva is slightly reddened and rather more than the normal number of large vessels are seen in it; its palpebral portion looks soft and velvety and may be slightly swollen, the margins of the lids are often thickened, giving a red bleary-eyed

appearance to the patient. The semilunar fold and caruncle are somewhat swollen and there is slight mucous discharge, some of which has very likely dried and formed crusts on the margins of the lids and at the canthi.

The occurrence of chronic ophthalmia, especially when it has not followed an acute attack, should always make us examine the eyes carefully, and we shall constantly find that it is due to some uncorrected anomaly of refraction, causing straining of accommodation and undue vascularity of the globe. Bear this in mind. If chronic ophthalmia is due to hypermetropia or astigmatism, buckets full of lotion will not cure it; correct the one or the other, and warm water soon sets it right.

Phlyctenular ophthalmia occurs most frequently in children, it is characterised by the presence of little white or grey bodies on the conjunctiva (phlyctenulæ) about which blood-vessels have collected, and which are most frequently situated about the corneal margin. There are generally two, three or more phlyctenulæ and they may be dotted over the corneal surface, or there may be one large one situated in the conjunctiva, away from the cornea and surrounded by a vascular zone; there is some mucous discharge and more or less lachrymation. The phlyctenulæ, when situated on the cornea or its margin, may suppurate, forming pustules, which break and leave small ulcers. In such cases, intolerance of light is added to the other symptoms.

Corneal phlyctenulæ, when rather numerous, going on to suppuration and ulceration, accompanied by severe intolerance of light and eczema or impetigo about the eyelids and face in unhealthy strumous children, make up what is described as *strumous ophthalmia*. Phlyctenular ophthalmia generally shows a lowered standard of health. Children affected by it are often delicate, their bowels are out of order, they suffer from worms or their teeth want attention, and they are, as a rule, improperly fed. Some patients are subject to constantly recurring attacks of the disease; in such, if old enough to read, look out for anomalies of refraction.

Membranous ophthalmia looks at first sight like a moderately severe purulent ophthalmia, for which you will very likely mistake it, but if you examine carefully, you will find the characteristic yellowish membrane adhering closely to the palpebral conjunctiva, from which it can be separated, leaving an abraded bleeding surface.

Diphtheritic ophthalmia you may mistake for purulent; its chief characteristic is a solid infiltration of the conjunctiva, with or without the formation of membranes on its surface; it is very likely to destroy the eye by causing sloughing of the cornea.

The disease is rarely seen in London and I do not remember having had more than two or three cases under treatment.

Treatment.—Here is a list of useful remedies—

Boric Acid Lotion ...	gr. x. to ʒi.
Sol. Hyd. Perchlor. ...	1—5000 1—2000 1—1000 1—500
Pot. Permang.	1—2000
Chinosol	1—2000 1—1000
Formalin 40 per cent.	1—2000 1—1000
Alum	gr. ii. to v. to ʒi.
Nitrate of Silver ...	gr. ii. to x. to ʒi.
Protargol	gr. v. to x. to ʒi.
Argyrol	2—20 per cent.
Argentamine, 10 per cent.	nitrate sil. solution
Argonine	1—10 per cent.
Cupric Sulph.	gr. i. or ii. to ʒi.
Zinc Sulph.	gr. i. or ii. to ʒi.
„ Chor.	gr. i. or ii. to ʒi.
Zinc Sulph.	gr. i.
Atrop. Sulph.	gr. i. to ʒi.
Acid Boric	gr. v.
Atrop. Sulph.	gr. i. to ʒi.

Solid Nitrate of Silver.

Green Stone.

Crystals of Cupric Sulph.

Mitigated Nitrate of Silver.

Argent Nit. ...	1 part.
Pot. Nit.	4 parts.

Yellow Oxide Ointment.

Hyd. Ox. Flav. ...	gr. ii.
Vaseline	ʒi.

Yellow Oxide Ointment with Atropine.

Hyd. Ox Flav. ...	gr. ij.
Atrop. Sulph. ...	gr. $\frac{1}{5}$.
Vaseline	ʒi.

Buller's shield.

A watch-glass fixed in the centre of a piece of indiarubber sheet.

The best treatment of ophthalmia can hardly be called treatment, for it is prevention, and on the principle that "prevention is better than cure," we will consider that first.

Take care that children and others suffering from catarrhal ophthalmia use towels, sponges, etc., kept specially for them, and on no account to be used by anyone else.

Wash the eyes of all newly-born children with a 1–4000 solution of perchloride of mercury.

Isolate all cases of commencing granular ophthalmia where possible.

Protect the sound eye by a Buller's shield in all cases where one only is affected by purulent ophthalmia.

When ophthalmia is established, first of all see that the greatest attention is paid to cleanliness. Discharge must be washed away frequently with some weak antiseptic lotion, none being better than a warm solution of boric acid, gr. x. to ℥i., and the lids must be prevented sticking together by the application of some kind of ointment applied to their eyes at bedtime. For catarrhal and mild purulent ophthalmia no further treatment is necessary.

In muco-purulent ophthalmia, in addition to what I have mentioned, we must pay attention to the cornea, and if ulceration is present, use yellow oxide ointment applied to the conjunctival sac once or twice daily, adding to it, gr. $\frac{1}{5}$ of sulphate of atropine to the dram if there is much intolerance of light: in many cases we shall find a good purge followed by some anthelmintic will be required, for children with muco-purulent ophthalmia are often troubled with ascarides.

Severe purulent ophthalmia, and especially gonorrhœal, whether occurring as ophthalmia neonatorum or in older persons, requires very energetic treatment, and I wish I could tell you of some plan by which we could, with tolerable certainty, cure severe cases. You can cure some of the less severe cases easily enough by the frequent use of astringent and antiseptic remedies, the frequency with which the applications are made being regulated by the amount of discharge, in most cases from four to eight times a day, with an occasional wash at night, will suffice.

In bad cases, amongst which the gonorrhœal are always included, occurring in patients other than infants, put your patient under an anæsthetic and clean the conjunctiva thoroughly with perchloride, permanganate, chinosol or boric acid solution. When all discharge has been washed away, pencil the whole conjunctival surface with a stick of solid nitrate of silver; cover the lids with a compress soaked in one of the solutions mentioned above and leave the case alone for two or three hours, then commence systematic hourly bathing and irrigation of the conjunctival sac with boric acid lotion aided by one of the stronger antiseptics, applied after every third or fourth bathing with boric lotion; the object to be attained is to keep the discharge washed away and prevent its reproduction. If one remedy appears to have no effect try one of the others; if, after three or four days, there is no improvement, apply the nitrate of silver again, continuing the lotion as before.

As soon as the discharge begins to subside use the application less frequently, and when the disease has lapsed into a chronic state, as it will do in the course of three or four weeks, use some astringent drops three or four times a day, and pencil two or three times a week with mitigated nitrate of silver.

In cases of ophthalmia neonatorum, in addition to the use of lotions paint the conjunctiva three times a week or oftener with a v. to x. grs. to ℥i. solution of nitrate of silver. If at any time during the treatment perforation of the cornea threatens, or takes place, apply the remedies less frequently and keep the eye bandaged with a pad soaked in antiseptic solution so as to support the cornea as much as possible and continue the pad and bandage till the perforation has healed.

Granular ophthalmia is best treated by astringents, antiseptics and mild caustics. Order drops of sulphate of copper, sulphate of zinc, nitrate of silver, or, if you prefer it, some of the more modern silver preparations, protargol, argyrol, argentamine, or argonine: protargol I have used largely and given it up, for I look upon it as an inert compound; of argyrol, argentamine and argonine I have no experience. Thus there are solutions of perchloride of mercury, chinosol, formalin and permanganate of potash, all of which may have a trial. All these the patients can have applied in his own home. Other remedies which you should apply yourselves are, lapis divinus or green stone, crystals of sulphate of copper and mitigated nitrate of silver stick. In some cases you can do good by everting the lids and rolling and crushing the granulations with a pair of forceps made for the purpose or by scraping them with a moderately sharp scoop, followed in either case by washing with solution of perchloride of mercury 1–1000 or even 1–500.

The latest treatment is, of course, electrical, Radium is being tried, X-rays, Finsen light and the high frequency current all appearing to do good.

When you start to treat a case of granular ophthalmia, make up your minds to a long job; in the most favourable case it will be a matter of many months, and in the least favourable, of years; there are some patients attending in the out-patient room to-day who have been under

treatment more or less regularly for thirty years, in whom the disease is kept in check but never entirely cured.

I have said enough to show you what you have to expect when you take on a case of granular ophthalmia and have mentioned a number of remedies; but it will, perhaps, be more useful if I give you a short routine treatment which you may vary according to circumstances.

In a recent case with luxuriant granulations give the patient an anæsthetic, evert the lids and roll or scrape them thoroughly, then wash them with strong perchloride; for the next day or two simply bathe with warm boric lotion; when the reaction set up by the treatment has subsided, pencil the lids three times a week with green stone or mitigated nitrate of silver stick, and give the patient sulphate of copper drops to use three times a day; a dropper of some kind should be always given to apply the drops with; it should be well filled with the solution and care be taken to empty it well on to the conjunctiva; this applies to the use of lotion or drops in all cases, which is always a difficulty, as patients or their friends generally manage to use the applications as a face-wash, never getting them into the eyes at all. In the more chronic cases, where the granulations have become flattened down or destroyed, be content to use green-stone and give sulphate of copper drops. Where there is much pain or intolerance of light, leave off all astringents, bathe with warm boric or belladonna lotions and drop in a solution of atropine three times a day until the pain or photophobia have passed off.

Chronic ophthalmia requires only the use of boric lotion or astringent drops, some ointment applied to the edges of the lids at night to prevent them sticking together, and do not forget careful correction of any anomaly of refraction.

Phlyctenular ophthalmia is easily cured by dusting calomel into the eyes two or three times a week, and the application of yellow oxide of mercury ointment every night, to which should be added, gr. $\frac{1}{5}$ of sulphate of atropine to ʒi. if photophobia is a prominent symptom. You must attend to the patient's general health, and if intestinal worms are present, or suspected, take measures for their removal.

Adopt the same treatment in strumous ophthalmia, but as there is generally a good deal of discharge, order boric acid lotion to be used three or four times a day. Give iron and malt, steel wine or cod liver oil, and see that the child is properly fed.

In membranous ophthalmia, bathe with hot boric lotion, infusion of poppy head, or belladonna fomentation; pull off the membrane and apply perchloride solution, 1–2000 or stronger.

Adopt the same treatment in diphtheritic ophthalmia, but in addition apply iodoform powder or ointment, and inject (hypodermically) anti-diphtheritic serum.

Disease of the lachrymal apparatus does not come within the scope of the present lecture, it is merely mentioned as a cause of discharge from the eyes.

With Dr. Shaw at Medical Out-Patients.

The following were among the more interesting cases which formed the basis for Dr. Shaw's clinical teaching at Out-patients' on a recent Friday afternoon:—

1. A market porter, aged about 40, stated that he had always enjoyed good health until the commencement of his present illness, with the single exception of an attack of acute pneumonia, for which he was for five weeks a patient in Guy's Hospital four years ago. His present illness began about a year ago, the first and chief symptoms having been swelling of the legs and abdomen. He had had three or four attacks of illness in the year, and in the intervals the swelling had entirely subsided. He was quite confident that in each attack the legs swelled before the abdomen and he said that he attributed the swelling of his legs to the large amount of beer he drank while at work, which often exceeded ten pints of "four-ale" in the twenty-four hours. Dr. Shaw pointed out that a trustworthy history of swelling appearing first in the abdomen and then in the legs always made it probable that an initial ascites or other cause of abdominal swelling was exerting pressure on the inferior cava, thus producing secondary œdema of the legs. Although this sequence is frequent in ascites due to cirrhosis of the liver, it should be remembered that in this disease œdema of the legs often preceded ascites, indicating some other cause for the œdema than caval obstruction. Pursuing the investigation of the case it was found that the legs were very œdematous and that there was little if any ascites. The liver was distinctly enlarged and somewhat tender. It was pointed out that a large and tender liver in association with œdema of the legs was very commonly due either to nutmeg congestion or to alcoholic cirrhosis. The members of the class were asked, *without examining the heart, to feel the liver and* endeavour by its physical conditions to decide which of these two lesions was the more likely. Its irregular edge, great hardness and very moderate tenderness were regarded by most of the class as indicating cirrhosis. The fact that the enlargement was not due to cardiac congestion was confirmed by an examination of the heart, which revealed no enlargement of the organ, a regular slow pulse

and no bruits. The second sound in the aortic area was noticed to be accentuated and meanwhile the urine was found to contain a considerable quantity of albumen and to have a specific gravity of 1020. Assuming that the provisional diagnosis of cirrhosis of liver was correct, the class was next asked to consider the possible relationship between the condition of the liver and the albuminuria. It was agreed that albuminuria was of frequent occurrence in the later stages of cirrhosis of the liver, and that then its presence was explained by the congestion of the renal veins due to the pressure upon them of the ascitic fluid. There being no ascites in this case, such an explanation could not hold good here. A suggestion from one member of the class that the alcohol which had given rise to cirrhosis of the liver had also given rise to cirrhosis of the kidney, was opposed on the ground that these two conditions were very rarely found in the post-mortem room in the same body, a fact which led many physicians to doubt whether alcohol was indeed a cause of nephritis. The idea that the enlargement of the liver was secondary to Bright's disease was untenable, because such secondary enlargement could only be in the nature of nutmeg congestion, through cardiac failure, and the heart had already been found to be doing its work well. Dr. Shaw said that beginners in medicine should do their utmost to explain by one disease or pathological process all the various symptoms and physical signs presented by a patient. It did not seem likely, however, that it would be possible to do so in this case. The only additional physical signs discovered were thick and tortuous arteries and a high tension pulse. These with albuminuria and the accentuated aortic second sound were considered to establish a diagnosis of granular kidney, while the alcoholic history and large hard irregular liver indicated hepatic cirrhosis. Those who did not feel justified in attributing both these conditions to alcoholic excess must at least allow that the existence of a granular kidney could not protect a man's liver from the results of the excessive drinking of beer. A man with Bright's disease, as indeed a man with any chronic debilitating illness, was likely to indulge in alcohol to counteract the depressing effects of his disease. The patient was admitted to the ward for further investigation of his case and for treatment.

2. A married woman, about 30, had been suffering for three years from pain beneath the sternum and between the scapulæ, with occasional vomiting. The pain was made worse by eating and lessened by vomiting. She also had a cough with expectoration, and two nights ago she brought up half a pint of blood. She had lately wasted and occasionally suffered from night sweats.

Dr. Shaw pointed out that the co-existence in this patient of symptoms pointing both to gastric and pulmonary disease made it of great importance if possible to decide at the outset whether the blood came from the lungs or the stomach, whether, in fact, it was a case of hæmoptysis or of hæmatemesis.

From answers of the members of the class the following scheme of differential diagnosis was agreed upon—

(*a*) *Character of ejecta.*—Colour, consistence, reaction, admixture.

(*b*) *Manner of ejection.*—Coughed, vomited or hawked up, the quantity brought up at one time, and recurrences.

In this connection Dr. Shaw said he found the most useful enquiry to be as to whether the main bleeding ceased suddenly or was followed by gradually lessening small quantities. The anatomical features of the stomach which enabled it to retain or dispose of any surplus blood and rendered it incapable of ejecting very small quantities, were in strong contrast with the system of bronchial tubes in the lung, which at once become blocked by any collection of blood and by the mechanism of cough were able to expel any accumulation within them, however small.

(*c*) *The existence of symptoms or signs of a disease likely to lead to hæmoptysis or hæmatemesis.*

Bearing this scheme in mind further enquiries were made under the various headings. It was elicited that it seemed to the patient that she *coughed* up the blood; in fact, this attack only differed as far as her own sensations were concerned from previous attacks in the amount of blood lost. She was, she said, in the habit of spitting phlegm, and on several occasions lately when she imagined she was going to do so she spat out some pure blood or blood-streaked phlegm. The severe attack occurred when she was in bed. She woke suddenly with a tickling in her throat and in three minutes, she thinks, brought up half a pint of blood. During the rest of the night and the succeeding day she frequently spat small quantities of blood. So far as the *manner of ejection* was concerned the facts pointed strongly to hæmoptysis.

Coming on in the night the patient was able to give but little information as to the *character of the ejected blood*, but she was confident that it was very dark, much darker than any she had brought up before. The class had previously agreed that *dark* blood should incline the observer to diagnose hæmatemesis and *bright* blood hæmoptysis, and on one member being appealed to for an explanation of dark blood in hæmoptysis, stated that sudden hæmorrhage from a large *vein* in the lung would perhaps be dark, but remembering his anatomy substituted the pulmonary artery as the possible source of venous hæmorrhage. The pathology of cavities with persistent bridles crossing them consisting of branches of the pulmonary artery, sometimes aneurysmal, was called to mind in this connection. The presence of diminished resonance, bronchial breathing and râles below the left clavicle led to a diagnosis of tuberculosis of the left apex, a condition likely to lead to hæmoptysis.

3. A man, aged about 35, had had syphilis four years ago. A year ago he was an in-patient with paraplegia, which was practically recovered from after eleven weeks in the hospital, the patient continuing to take medicine only for a fortnight after his discharge. A recurrence of weakness in the legs a little more than a month ago had already greatly improved after three weeks' treatment as

an in-patient. Relapsing paraplegia, speedily affected by treatment, occurring in a syphilitic patient, clearly pointed to some gummatous lesion of the cord. An interesting point was raised in this case as to the necessity of persisting in antisyphilitic treatment for a long time after the removal of symptoms due to a tertiary lesion. In primary syphilis it was by many teachers regarded as an axiom that treatment should be continued for two years. No such clear principle of treatment appears to be laid down for tertiary syphilitic lesions, but it is a good rule at Out-patients to prescribe iodide of potassium alone or in combination with liquor hydrargyri perchloridi as long as the patient can be persuaded to attend. As indicating the limited character of the lesion in the dorsal cord, Dr. Shaw pointed out the absence of wasting of the muscles of the legs, the presence of rigidity and exaggerated knee-jerks, and the special nature of the trouble with the bladder of which the patient complained. The state of the muscles of the limbs showed that the anterior grey horns in the lumbar enlargement were intact (absence of wasting), while the lateral columns in that part of the cord were sclerosed (rigidity and increased jerks). As to the bladder, the patient stated that he was always aware when he wanted to pass water, and that the act of micturition was perfectly performed without dribbling or hesitation. His only difficulty was that the moment the desire to micturate arose the act become uncontrollable. This indicated a perfect centre for micturition with normal afferent and efferent paths. The central control from the brain was cut off by some lesion in the cord above the centre for micturition. The patient was ordered five grains of iodide of potassium in an ounce of the mercuric perchloride mixture three times a day after meals and advised to continue his attendance at out-patients as long as possible.

4. A man, about 55 years of age, who had a fortnight before become suddenly blind in one eye, was sent from the eye wards for an opinion as to the cause of the retinal hæmorrhage (? venous), which had been found by the ophthalmic surgeon to be the explanation of the blindness. Dr. Shaw said that as there seemed some doubt as to whether the bleeding was arterial or venous, a careful search must be made for the usual causes of retinal hæmorrhages of any sort. Cases of this character were sent frequently from the eye wards, and in the great majority of instances were found to be suffering from either Bright's disease or diabetes. Some were cases of well-established Bright's disease, while in others the urine was quite normal, although there were signs of high arterial tension. This class of retinal hæmorrhage, causing blindness in people believing themselves healthy, was in contrast with cases often seen in the wards in which a patient seriously ill with pernicious anæmia or ulcerative endocarditis was found, on careful examination, to have a few retinal petechiæ or extravasation, producing no subjective symptoms. In the case under consideration no symptom or physical sign of disease in any organ, apart from the eye, could be discovered. This gave strength to the opinion expressed in the eye wards that the hæmorrhage was venous. Such venous hæmorrhages into the eye occurred in healthy women during parturition. It was suggested by one of the class that it might have been due to the man, who was rather stout, stooping down and fastening his bootlace, and by another, to violent retching. But the patient could remember no such cause, and said that he first noticed his loss of sight one morning at breakfast. It was agreed, however, that sudden loss of sight of one eye was often only recognised accidentally some time after its occurrence. Dr. Shaw said he must report to the eye department that there was no sign of any circulatory or visceral disease likely to give rise to hæmorrhage.

Pass List.

University of Cambridge, April, 1904.

DIPLOMA IN SANITARY SCIENCE.

Myer Coplans.

University of Durham, April, 1904.

THIRD EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

A. A. Smith.

FIRST EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

Elementary Anatomy and Biology.—L. K. Edmeades, J. F. Young.

Chemistry and Physics.—H. C. W. Allott.

Final Conjoint Examination, April, 1904.

Medicine and Midwifery.—S. D. Jacobson.

Surgery and Midwifery.—J. Cook.

Medicine only.—*J. Bromley, G. F. Hardy, *H. F. Hatfield, H. H. Jenkins, F. C. R. M. Knight, *B. Moiser, *C. S. Morris, *G. Nunn, G. W. Russell, *H. M. M. Woodward.

Surgery only.—*H. O. M. Beadnell, *J. C. O. Bradbury, *F. H. Parker, *E. W. Routley, H. L. Shelton, O. B. Travers.

Midwifery only.—A. R. Beaumont, R. D. Bridger, G. H. Cheyney, J. H. Clatworthy, C. J. S. Dismorr, C. P. Harvey, A. S. Littlejohns, F. B. Lowe, A. V. Maybury, B. Muir, L. Myer, G. H. Rees, G. C. F. Robinson.

* Denotes completion of the examination.

In Lighter Vein.

GAZETTE PRIZE COMPETITION.

"I had rather have a fool to make me merry than experience to make me sad."

This Competition has evidently excited considerable interest, 71 lists of answers having been received, of which 64 were from men, including several members of the Junior Staff, Residents, and past and present Students. The ladies who entered were in a distinct minority, only 7 having the courage of their opinions.

It was suggested that the Competition should be held over for another fortnight, but the Competition Editor who, since April 23rd, has spoken only in Shakespearian quotations, remarking :—

"Defer no time, delays have dangerous ends,"

decided that our readers should not be held in suspense any longer; so at great pain and inconvenience to himself he retired from the Hospital and from his work for a whole twenty-four hours in order to achieve his end. He was found at the expiration of this time with a wet towel round his head and in a semi-comatose condition, on being roused from which he could for a long while say nothing except—

"Out! Damned spot!"

His work has been rendered very much heavier by the numerous letters he has received on the subject, some of which are congratulatory epistles rejoicing at the exposure of the weaknesses of their dearest enemies, whilst others were from personages who have written protesting at the "thinly-veiled, brutal caricatures" of themselves embodied in the several quotations. To this latter he can only offer the following words of advice.

"Happy are they that can hear their detractions and put them to mending."

The fortunate winner of the prize of One Guinea is

Mr. Walter Reeve,

whose list comprised no fewer than 18 successful answers out of 24.

[We hope to publish an interview with this gentleman in a future issue with a full length portrait.*]

*Will Mr. Reeve kindly forward photograph.—Ed. G.H.G.

No one will question the decision of the Competition Editor for, as he characteristically assures us,—

"His words are bonds, his oaths are oracles,
His heart as far from fear as heaven from earth."

Several competitors followed the winner very closely, one list comprising 16 correct answers, and no fewer than 17 having 14 answers correct. If some of the anxious compilers had been a little less busy with their correction and re-correction they would have scored more heavily—to quote from the same source :—

"Striving to better, oft we mar what's well."

As regards the replies, we have been asked on all sides to publish a complete key, but this is manifestly impossible. There are some who might be offended at such a course of action, and for this reason we have thought it better to suppress answers to numbers 5, 7, 13, 14, 16, 18 !

To the seven gentlemen who wrote complaining that 16 was meant for themselves, we can only express our regret that they should thus have opened our eyes to their failing. The quotations to which almost all the competitors gave correct answers were numbers 1, 3, 4, 8, 14, 17, 21, and *almost without a single exception* 18.

The numbers that seemed to present the greatest difficulty were 10, 15, 19, 22, 23 and 24, the last one (only guessed by one competitor), referring to a well-known official whose decorated breast is perhaps more familiar to the junior than to the senior men. No. 20 was guessed by a very fair percentage, but we have it upon the authority of the individual himself that he does not "sleep o' nights."

For a correct list minus the above-mentioned six numbers apply to Mr. Croucher at the Medical Office.

We are sure that all will congratulate Mr. Reeve on his remarkable success, evidently

"In his brain
. . . . . he hath strange places crammed
with observation."

The competitors also who ran him closest are to be complimented upon their insight and malevolence.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Letter from Sir Samuel Wilks.

Sir,—I thank you very much for your kind congratulations and notice of me in your last week's journal. I take the opportunity of saying that I scarcely know how to express my feelings when thinking of the tokens of friendship and kindness shown me during my late illness. These, coming from so many friends, have almost overwhelmed me, and I fear that owing to the anxiety of those around me all the names of my benefactors have not been preserved, and therefore I may not be able to thank all those who wrote me letters of sympathy and hopeful encouragement, besides sending me beautiful spring flowers and various delicacies.

I ought especially to remember my own school, where all my colleagues vied with one another to assist me in my trouble First in my memory stands Pye-Smith, whose great experience and judgment came early to my aid; his daily visits I more valued because I was aware of his numerous duties, more especially those connected with the University of London. I am sure everyone will join with me in congratulating him on being placed in one of the highest positions which any man in our profession can hold—that of Vice-Chancellorship of a great University.

Next I think of Mr. Symonds, to whose skill I have no doubt I owe my life. When I remember his arrival as a student from one of our Colonies and his subsequent career and present position in the profession, I regard him as one of the men to whom we have been looking, who, by his original and independent mind, will preserve in the future empire the old English traditions in the sphere of medicine.

Then comes my old friend Mr. Wornum, who assisted Mr. Symonds in his work, and whose continuous and unremitting care and skill have been so instrumental in conducting me through my illness. It is impossible for me to give him the thanks which are his due.

Could any mortal being have been placed under more favourable circumstances than myself during the illness from which under God's mercy I have recovered from. The great judgment of Pye-Smith, the skill of Symonds, the close attention of Wornum, and the sympathy and prayers of a host of friends—all these were contributing towards a favourable result.

I can now do no more than thank all my kind friends, and more especially Guy's men, and I again thank you, Sir, as their spokesman.—Yours faithfully,

SAMUEL WILKS.

Letters from other G. P.'s.

No. 1.

Sir,—Your correspondent "Worldly Wiseman, M.D.," utters the same complaint that every now and then appears in the medical journals. He complains that the whole art and practice of medicine is not to be learnt at a hospital. I cannot imagine why anyone should suppose that it should be possible to learn what is practically the business of medicine within the walls of a hospital. This can only be acquired by actual experience, and can be best attained by some months spent as an assistant to a medical practitioner in general practice. At the same time I think it would be quite possible to get valuable advice on the subject if a course of lectures in the *practice* of medicine were given in a medical school by a general practitioner during the summer term. It would be very easy to enlist the services of some retired or little occupied G. P. for the purpose. He would be able, in the first instance, to expose the cant and humbug of the "introductory lecture" that we hear of at some hospitals. He would be able to tell the coming medical men what general practice really is, what is expected by patients and what the doctor should himself expect. He would tell them what patients consider "treatment"; what patients know about diseases and about drugs. He would teach them, not merely to cure disease, but how to become a successful man. Under the latter head would come the art of blowing one's own trumpet, the art of judicious advertisement, the art of getting on with fellow practitioners—which latter art is usually termed "medical ethics," and consists largely of "doing as you would be done by," and behaving more or less as a gentleman.

The question of "fees" would certainly take up a whole lecture and is a very difficult subject. Fees range from the generous guinea down to anything, according to the radiograph of the patient's pocket. The dress of the doctor could also be touched upon and the relative value of the spotless dapperness of the medical masher who can afford the best tailor would be contrasted with the battered, untidy, sartorial equipment of the medical genius, too busy to attend to personal adornment.

Another lecture could be well occupied with what one might term "The Tricks of the Trade." These would mostly be mentioned with a view to their being avoided. Under this heading come "Bob Sawyer" dodges of bogus messages when in church or at the theatre; bogus operations in the consulting-room just before a patient is seen, as demonstrated by a disordered display of instruments, towels, etc.; the hired carriage or motor that pursues its wild career about the principal streets of the town bearing the doctor to imaginary urgent cases; tips to hall porters of hotels and lodging houses; the mystery of the "split fee," whereby the anæsthetist or assistant is cheated at an operation. There is the art of dealing with hysterical patients of erotic tendencies, and the methods to be pursued towards insulting proposals of malpraxis without calling in the police or kicking the proposer downstairs. There are hundreds of other things that could be talked about with advantage in such lectures; heaps of useful knowledge that could be given to the science packed student; and lastly, as an entertainment on a drowsy summer's afternoon, they would be hard to beat.—Your obedient servant,

F. V.

No. 2.

SIR,—It is a sad reminder of the gross materialism of the day that Worldly Wiseman claims his cunning—low cunning, I had almost written—to be his most valuable possession. The G.P. is evolved from the student, and figs are not grown on thistles. The keen student makes the keen practitioner. Pity the poor man, who, stored merely with the catch-words of our craft and the cunning of Worldly Wiseman, has to endure day by day the monotonous round of his task, the "insolence of office," the haggling over shillings, and the constant affronts to a well-born man of sensitive disposition, inevitable to his position as a G.P. Such an one takes no scientific pleasure in "a good case," nor feels the thrill of satisfaction that comes to a trained mind when it has wrestled with and solved a knotty problem. It is only the scientific aspect of our work that makes us endure the sordidly commercial side of it with some equanimity.

Prognosis of disease I maintain cannot be taught, but must be learned by a copious experience of sick folk. No man who values his future and his self respect should join the ranks of the struggling practitioners until he has done at least two years of post graduate work of which one should be spent as an officer in a large Poor-Law Infirmary. In no place in the world will he have such an opportunity of observing a congregation of patients suffering from the every-day complaints that bulk so large in private practice. He will learn by experience how long phthisis and cirrhosis and pneumonia take to kill—he will learn a far more important lesson—never to despair. He will learn what drugs are useful and their limitations; he will despise the great bulk of drugs. He will learn that a given disease under such a règime will be cured in ten days or a month, as the case may be, and such knowledge will be of enormous help to him. Others may say this or that, but he goes grimly on his way—as Omar puts it—He knows! He knows! I cannot agree with Worldly Wiseman that the G.P. needs not to be instructed in the use of the ophthalmoscope or the laryngoscope. It is absurd to say a man has no time to learn them. Let him abandon the useless stewing over books in the Library for an hour each day, and at the end of his time he will have a good working knowledge of the instruments. When he gets into practice it is easy to keep up that knowledge. No patient ever escapes unexamined from my consulting room whose eyes or larynx I can find any excuse for looking at. Far be it for me to despise the "cunning" of Worldly Wiseman, but it should be part of a doctor's intellectual equipment as a scientific man—the science of psychology.

In short a medical student should learn the scientific aspect of his work, nor neglect any means attainable to arriving at good diagnosis; incidentally he must pick up—tact. Worldly wisdom cannot be expected of a young man of four-and-twenty—if he is worth his salt the world will teach him soon enough. In conclusion, I differ *in toto* from Worldly Wiseman when he says that prognosis is the most essential attainment. The doctor who can make a lame man walk, cure a chronic headache, improve the hearing or the vision is the man who will reap his reward in gratitude—and shekels. And that some gratitude is worth a lot of endurance, of monotony, and hard work.

Stick to it boys! Enthuse over every "good case." You will want all the enthusiasm you can come by later on to compensate for the indignities and the pettiness of private practice.—Yours, etc.,

"A FELLOW."

Abnormal Proportions of a Foetus.

DEAR SIR,—Mrs. T. S., æt. 35, a cowman's wife, was delivered of a female child on April 7th, 1904, having the following herculean weights and measurements:—

Total length	23¾ inches.
Circumference of neck	10 "
" round shoulder ...	20 "
" " chest ...	16½ "
" " pelvis at crest	15½ "
Weight	30 lbs. 4 oz.

The mother is just over five feet high, with broad hips and roomy pelvis, and three years ago gave birth to a child weighing eighteen pounds.

The labour was difficult but natural and not unusually long; no instruments used or chloroform given and no injury to maternal parts. A point of particular interest is:—I was engaged to attend on September 9th, 1903, for "about the first week in February," the patient stating that her last period was early in June. From a medico-legal point of view the case seems interesting. The patient herself thinks her pregnancy has lasted just eleven months, and the size of the child certainly lends weight to this. The child died during delivery. I am sorry to say I did not witness the weighing but have no doubt as to its correctness.—Yours truly,

EDWARD H. GREAVES.

Chapel Choir.

DEAR SIR,—I beg leave to announce that a general meeting in connection with the Guy's Hospital Chapel Choir will be held on Wednesday next, May 11th, at 5 p.m. in the Court Room. Although it would be a very great matter for regret should the choir be disbanded, yet it is still more deplorable to see only two or three men at their posts Sunday after Sunday. The present situation calls for the earnest attention of all who are in any way interested in hospital chapel music, and if a little enthusiasm could be awakened, especially amongst the junior men, much might be done towards recovering the ground that has been lost of late. The plan upon which the working of the choir depends is a very simple one. Each member is asked to attend on one Sunday in every four, or failing that, to find a substitute, who must also be a member. A membership of forty will thus entail a regular Sunday choir of ten. Regular attendances is not therefore a *sine quâ non*, and the

greater the number of members, the less the work for each individual member.

Further information can be obtained from Mr. Henry Taylor, the organiser of the choir, or from myself.—Yours truly, RICHARD FELTON.

A Case of Depressed Fracture. Fractured Base. Operation. Recovery. No Sequelae.

J. P., æt. 15. Storeboy; was admitted under Mr. Clement Lucas on December 4th, 1897.

History.—Patient was climbing into a van when he slipped and fell on the back of his head. He was picked up unconscious and hurried to the hospital.

Condition on admission.—Deeply comatose; bleeding from nose, mouth and left ear; pulse very poor and could not be counted; collapse was so severe that some brandy was injected at once. Respiration was very slow and failing rapidly. Cyanosis, depressed pond fracture three inches in diameter above and behind the left ear.

Operation.—This was performed as the patient lay on the stretcher in the surgery within five minutes of his admission. Immediate operation seemed to offer the only chance, and there was no time to summon Mr. Lane or even to take the boy to the theatre. A semilunar flap of scalp was turned down behind the left ear, and a vertical incision was carried upwards from this wound to give more room. The parieto-occipital suture was seen to run vertically down across the middle of the pond-depression. A furrow was rapidly made along this suture by means of a Lane's rectangular edged chisel, and an elevator was inserted to raise the fragments into position. Directly the bone was pierced there was a gush of blood from the extradural space. Soon afterwards the boy became restless and Mr. Stamford gave him a little A. C. E. to keep him still during the completion of the operation. A gauze drain was left at the lower corner of the wound, for the preliminary cleansing had been necessarily very hurried. The patient very slowly rallied, got somewhat excited during the following day, and had some morphia given to him subcutaneously. The temperature was about 100° every evening for the first four days.

December 6th, it was noticed that there was paralysis of both external recti, with double lateral diplopia, especially in the lower half of the field; the false images were vertical. There was also complete left facial paralysis and almost complete paralysis of both auditory nerves. The left leg was weak and so was the left side of the tongue.

A fracture of the left scapula was discovered, extending from the vertebral border above the spine downwards, and outwards to the axillary border.

The reflexes were normal; there was no anæsthesia and no loss of smell.

12th, paresis of both third nerves was noticed, the right was the worse, there was ptosis on this side only, and the pupils were unequal. No optic neuritis at any time. Loss of power of taste on left side of tongue. Pulse slow, 50–60 per minute. Hemicrania on left side. Right otorrhœa. The left leg is improving. Gradually these various paralyses improved, but the left side of face and the right external rectus were still paralysed when the patient left the hospital on February 13th, 1898.

These slowly recovered, with the aid of electrical treatment, and the boy was quite well about six months from the accident. He afterwards joined the army without telling the doctor anything about his accident. While stationed in China, he happened to get a slight malarial attack, and he then suggested to the doctor that his headache might be due to his old head injury. Thus the scar on his head was discovered, and he was discharged forthwith, although he had won a shooting prize and was in excellent health.

I saw him a few months ago and then I could find nothing wrong with him, except a very narrow and shallow groove over the site of the operation; but there was no depression and no pulsation. There was no facial or other paralysis and the hearing was good. He now works hard as a labourer.

I have thought this case interesting for several reasons. It is now more than six years since the accident, and the man is now quite well, and he has not had any fits or headaches, or any of the other sequelae so commonly found after severe head injuries.

The case impressed upon me at the time of the operation the great advantage of the parting tool over the trephine in a case where immediate relief of pressure is demanded. It takes very little time to remove a piece of skull with this chisel, much less, than with the trephine. It also shows that no case of compression need be considered too desperate for operation, and that prompt treatment may sometimes save an apparently hopeless case. A striking feature, was the implication of so many cranial nerves. There was paralysis or paresis of numbers 7, 8 (both), 6 (both), 3rd (both), and 12.

It is almost certain that the fracture of the vault extended downwards to the base and across the posterior fossa through both petrous bones, and the basi-sphenoid behind the dorsum sellæ. This would account for the complete paralysis of the 6th, 7th and 8th nerves, the discharge of blood from the left ear, and the suppuration of the right middle ear later on.

The paresis of the left leg was probably due to some bruising or even laceration of the right motor area, high up, by contre coup, the depressed fracture being low down on the left side. The paresis of the other cranial nerves was of later onset, and was never complete, and was possibly due to intradural hæmorrhage gravitating to the base, and subsequent aseptic meningitis arising from this. The loss of taste in a part of the tongue was caused by the facial paralysis, the nerve being compressed by blood clot in its bony canal before the chorda tympani leaves it to join the lingual.

I am much indebted to Mr. Lucas for allowing me to publish this case, and also to him and to Mr. Lane for generously forgiving me for operating in their absence.

R. P. ROWLANDS.

Hospital Ideals=A Nightmare

AT the starting of a new term and the sight of strange faces in the Smoking Room it is perhaps permissible, for one who has seen more than one session, to indulge in philosophic nightmares on subjects to which the average freshman devotes little thought. Sermons are usually more odious than comparisons, and meditations amidst smoke fumes and on a diet of bar rissoles are bound to be wearisome, especially to the new man who comes up to Guy's to do great deeds or perish in the attempt. Let me say at once that I have no fault to find with him. For this is a nightmare, not about the things he has got, but about those his fellow students have not—ideals. We all come to Guy's with some ideal, were it only that of leading the two guinea a week existence of a country locum, or of wearing the gorgeous garb which a Licentiate of the Society of Apothocaries dons on high days. Guy himself had some, if what little we know of him can be trusted, and Tamworth and Southwark Borough can show how well he realized some of his hopes at least. We, alas, drop ours very soon, some in the Chemistry Laboratory, others, wearying a little later, in the Anatomy Theatre, and others again in the Dressers' room, where they vanish from sight with the empty sardine tins and the lank bone of a badly hacked ham. But few of us stick to them, and if a statistical record of our abandoned hopes could be compiled, how grimly would it comment on the saying that a man's reach should exceed his grasp.

Not that it is the prime failing of freshmen not to possess an ideal. I have met many with these accessories, some very queer ones. Literary aspirants who set as their goal the membership of some Bohemian club where the men wear their hair long, and the women wear theirs short—political devotees who hope to make budget speeches without the assistance of a monocled parent—men who saw house surgeoncies and Wimpole Street in rapid succession, and now travel for somebody's whisky. One has met all these, though the majority seemed to wish for nothing better than a modicum of athletic fame or the ability to emulate the prehistoric man at the Tivoli in that system of exaggerated ungracefulness which is called a "Cake Walk." It is the fashion for English boyhood to look down on foreign students as it is for their elders to carp at what Mr. Golding Bird once termed "Continentally exhaustive scientific treatises." It is easy for us to run over the gamut of a German's iniquities in the beer drinking, the shouting and swearing and braggadocio duelling line, just as easy as it is to forget that we take our cricket and football very seriously indeed, and our professional duties very lightly, at least while we are in the lower school of it all. No doubt we can find excuses for all that on the score of thoroughness. Thoroughness is an admirable quality—even in liars, as Oscar Wilde pointed out when he went into rhapsodies over the American who capped the Frenchman's declaration, that Paris boasted a brick on which some Assyrian monarch had entered his laundry bill, by remarking that at Washington they treasured the "blue pencil with which Noah ticked off the beasts as they came out of the ark." But in one direction only it is apt to run amuck. Compare Herr Studiosus Medicinæ drinking jackboots full of bad beer in the Elberstrasse at Erlangen, and kissing Marienchen unblushingly when she brings the skat cards, and the Guy's man lolling at the Strand Cabin on a Saturday afternoon. For my part I prefer the crowd in the Elberstrasse tavern, where the beer is vile and the tobacco filthy, and the vulgarity more honestly open, even though my German student reels home at night, and finds when he takes up his Heintz that the bifurcation of the aorta has progressed upwards as far as Chassagnac's tubercle, and that he sees Purkinjes figures and sometimes worse all over his coverlet.

After all this is a nightmare—a mis-application. I am not going to assert that the Continental student is more idealistic, or more true to his ideals than the English. If I were, there is Emin Pasha's letter to Dr. Felkin to give a flat contradiction. Nor would I go so far as to say that because Napoleon's soldiers carried each a potential field marshall's bâton in his knapsack the freshman should feel it his duty to cart a midwifery forceps in his dressing case, altogether apart from the fact that it is open to argument whether midwifery forceps are symbolic of human surgical ambition. Turn to the Biographical Dictionary—that admirable collection which every Guy's man ought to have on his shelves—and you will find how many of us held to their first faith and attained to something very near greatness, even Galloway, who died in Sydney tended by his old dissecting-room pupil. Could Thomas Guy himself come back and look at his institution to-day it may safely be said that he would find little to grumble or cavil at. He might object to some things, to the new college wall-paper for instance, which it is doubtful whether even his miserly soul would find favour with on the score of cheapness, and to the waste of lint and bandage in the front surgery. But to others, what? He played at skittles himself—with South Sea shares, and would doubtless consent to take a hand at tennis at Honor Oak were it proved to his satisfaction that he could borrow someone else's racquet and shoes, and that he would not have to stand a drink afterwards. He would tolerate the weekly football exodus during winter term if the examination results and the silver in the smoking-room were discretely pointed out to him for his inspection. He might even wink at the Saturday displays at the Cabin, for do not his enemies say that he himself, before he became old and miserly, "carried on" with one surnameless Mary, who brought beef and carrots to the back benches at the "Bull and Grasshopper."

After all, this is a nightmare, due to bar rissoles and milk half-and-half!

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Notes from Skin Outers.

Urticaria.

Urticaria means "nettle-rash," and the typical disease is characterised by the rapid appearance of pale wheals, which are markedly asymmetrical, surrounded by a hyperæmic zone and accompanied, as a rule, by much irritation, with consequent scratching, and frequently the formation of fresh wheals as a result. Individual wheals usually only last a few hours at the most, appearing and disappearing suddenly, but successive crops may keep on succeeding each other so that the attack lasts weeks or even months or years (*U. chronica*). Thus, Sir Cooper Perry had a man aged 66 attending his out-patients who had been suffering from urticaria for fifteen years, and another man aged 50 who had been troubled with itching at night for the past ten weeks, but who ascribed the cause of his ailment to being poisoned with eating fish six years previously.

On the other hand, the disease may be very acute and of short duration (*U. acuta*). Such cases may be accompanied by febrile symptoms and a temperature of 3 or 5 degrees Fahrenheit above the normal.

U. perstans is a term applied to cases where the wheals tend to remain obstinately instead of making simply the evanescent appearance characteristic of the typical disease. Such wheals may last for weeks.

Urticaria may attack mucous membranes as well as skin.

The pathology of urticaria is the result of vaso-motor disturbance causing dilatation of blood-vessels, with consequent localised œdema of the upper layers of the integument causing the wheals.

The following varieties must be mentioned :—

1. *Urticaria papulosa* (lichen urticatus, or lichen strophulus, as it is also called) occurring in babies, and leaving persistent papules or even vesicles, which have to be diagnosed from scabies or varicella according to their distribution. The spots come out in crops at nights, and the total duration of the disease, with the occurrence of these sudden crops, may be several years.

2. *Urticaria Pigmentosa*, which commences in infancy —usually under six months of age—and consists of persistent wheals, at first bright red, gradually changing to dark brown, which, while still remaining, are followed by successive fresh crops. The disease is symmetrical, affects chiefly the neck and trunk, and is more common in boys. The stains left are like those of a secondary syphilide. It is due to infiltration of the papillary layer of the corium, by what Ehrlich calls "mast-cells" or "mastzellum." R. Crocker describes three forms of U. pigmentosa—

(*a*) Nodular.
(*b*) Macular.
(*c*) Maculo-nodular.

The last is the commonest.

3. *Quinckes' disease* or *acute wandering œdema* is a somewhat rare complaint; large cutaneous phlegmonous patches attack the orbital tissues, face or limbs—rarely the trunk. These disappear in one part to reappear in another; there is usually no "itching," but much "burning."

4. *Urticaria factitia*, is a condition where wheals can be produced at will by scratching; thus the patient's initials can be written on his skin. There is an excellent wax-model representing this condition of things in the museum at Guy's.

5. *Urticaria ab ingestis*, by far the commonest variety; due to eating shell-fish, pork, or porridge, or some other food for which the individual may have an idiosyncracy, and by which the skin is affected reflexly through the vagus.

Sometimes blood may be effused into the wheals (*U. hæmorrhagica*), or vesicles or bullæ, may form (*U. bullosa*).

Predisposing conditions are a neurotic temperament, infancy, the female sex, gout and malaria, and among exciting causes should be mentioned, stings of nettles, jelly-fish and insects, and insect bites; and in some cases apparently a chill. Treatment resolves itself into internal and external remedies.

Internally mild purgatives and intestinal antiseptics are indicated. Thus, Sir Cooper Perry has prescribed :—

Sodi Sulphatis	ʒi.
Salol	grs. 8.
Muc. Gum Acaciæ	ʒii.
Syrup	ɱ 30.
Aq.	ad. ʒi. t.d.s.

or again—

Beta-Naphthol	grs. 7.
Bismuth Salicyl.	grs. 12.
Pulv. Tragacanth Co.	grs. 12.
Inf. Aurant. Co.	ad. ʒi. t.d.s.

In other cases Antipyrin does good, and of course any general disease such as malaria should be treated: in infants grey powder may be administered.

Externally soothing, cooling and mild antiseptic lotions are to be recommended. Thus, Sanitas and water equal parts (Crocker), or—

Ac. Hydrocyan. Dil.	ɱ 10.
Sodii Bicarb.	grs. 20.
Ac. Borici	grs. 20.
Calaminæ	grs. 25.
Muc. Acaciæ	ʒ 1½.
Aq. ad.	ʒi.

ft. lotio. To dab all over on going to bed.

(E. C. P.

or—

Lotio Plumbi Subacet. Dil. ...	ʒ ½.
Methylated Spirit	ʒi.
Aq. ad.	ʒi.

ft. lotio. p. a

If an ointment be preferred the following are to be recommended—

Ung. Ac. Salicyl.	(B.P.)

or—

Balsam of Peru	1 part.
Lard	9 parts.

or an ointment made by rubbing up Lanoline with Tr. Benzoni Co. may be found effectual, particularly with infants.

Real Conversations.

(With apologies to Mr. Keble Howard and the *Daily Mail*.

SCENE: The smoking-room, 12 a.m. Tall, blotchy youth seated at small round table near fireplace. On a plate in front of him lie two disconsolate looking dead prawns, a bit of brown bread, a scone, and a piece of shortbread; this combination, for the sake of euphony being called "Lunch." To him approaches a Nondescript Youth.

N. Y. Well, Long'un, how did it go?

Long'un. (With a "very weary after my exertions, but may just survive" sort of air). Oh, knocked 'em, thanks.

N. Y. Good man (shakes hands effusively) I knew you'd be all right (this Liar having been heard to remark that "if Long'un got through, he'd be blest if he did'nt take the whole three himself next time).

Long'un. Thanks.

N. Y. What did they ask you?

Long'un. Nothing very bad—had a rough time in anatomy though.

N. Y. Ah, anatomy's the thing.

Long'un. The chap asked me such funny questions, sounded more like breakfast table problems than anatomy.

N. Y. Ah, they do rag you, don't they?

Long'un. I managed to bluff through somehow though.

N. Y. Good man.

Long'un. Yes, its a good thing to have off your chest.

N. Y. Rather, I wish I'd gone up this time; I could have done that paper.

Long'un. (Doubtfully) Could you? I thought it was a bit hot, but I wrote a lot, I thought some of it was sure to be right.

N. Y. What Clinicals did you have?

Long'un. Oh, man with a tongue, kid with a knee, woman with a breast and a girl with a foot.

N. Y. Ah! (Another Nondescript Youth approaches.)

2nd N. Y. Hullo, Long'un, how was it, eh?

Long'un. Oh, knocked em, thanks.

2nd N. Y. Did you! good; but it was an easy paper.

Long'un (slightly nettled). Think so, I did'nt.

2nd N. Y. Oh, it was all right; what clinicals did you have?

Long'un. Oh, woman with a breast, man with a tongue——(Two more N. Y's. approach).

N. Y.'s. Hullo, here's Long'un—get pipped, Long'un?

Long'un. No, just managed to knock 'em.

3rd N. Y. Good, that's the sort.

4th N. Y. Good old Long'un, have an easy time?

Long'un. Had a rough journey in anatomy.

3rd N. Y. What did they show you?

Long'un. Kid with a knee, woman with a——(and so on till about 2 o'clock, when he strolls over to the Colonnade to receive the congratulations of such members of the Staff as know that he exists).

OUT-PATIENTS.

USUAL scene: Eminent Surgeon, surrounded by Eager and Intelligent class. Anxious looking, but shapeless mother, carrying baby, approaches and sits gingerly on seat in front of Eminent Surgeon.

E. S. Well, what's the matter with——

Baby (suddenly catching sight of a member of the eager and intelligent class) Ah—O-o-o-o, oh! E-e-e-e. Ah-ha-ha.

Mother. There-there-there, 'e wont hurt you ducky. Tzch-tzch-tzch. There—there, my pritty.

E. S. What is the——

Baby (catching sight of E. S.) Wow-ho. Gurgle. Choke. Ah-a-a-ah—Wow.

E. S. (loudly). What's the matter with the baby?

Baby. Wow.

Mother. 'E's cutting his little teeth, sir, I think. Hush then deary, there-there.

(Man in uniform enters and gives clerk a paper. Baby catches sight of man in uniform, and goes purple in the face with temporarily suppressed indignation—then——)

Baby. Wah-hoooo. Yah-e-e-e. Oh-ou-ou-ou.

E. S. Yes, yes, yes; but what have you brought him up here about?

Mother (blankly), I ai'nt brought him up sir.

E. S. I mean, besides his teeth, what's the matter with him?

Mother. Lor bless you sir, there ai'nt nothing the matter with him, though he is the youngest of seventeen, all alive and doing well, and 'ealthy too, barring my fourth what met with a haccident, all along of them electric trams with their ringin' and rattlin' one after the other, that it ai'nt safe for a baby to cross the road without being made to jump out of their skins, which poor feller he fell down in front of and got his arm broke and the sole of his boot taken off, as was lucky it was'nt his leg.

E. S. (with the calmness born of much experience). Then you've come up about yourself?

Mother. Yes sir.

E. S. Well, what is it?

Mother. It's my leg, sir; it's bad sir (produces a huge varicose ulcer).

E. S. (to a member of the eager and intelligent class.) Well A—what's that?

A. (after pondering deeply over many possibilities), its an ulcer, sir.

E. G. Yes, its an ulcer; what sort of ulcer do you think?

A. (after more thought), I should say it was chronic, sir.

E. S. Yes—well—B, can you tell us something more about it. (B leans forward to examine it, and wakes the baby who had gone to sleep.)

Baby. Ah-ha-ha, oh-ou-e-e-e-eee.

Mother. Hush then, hush my pritty—tzch, tzch.

E. S. Well B? (B looks wise, but remains silent.)

E. S. What are those blue things, zig-zagging about, above and below the ulcer?

B. (a bright light breaking in on him), veins—its probably a varicose ulcer sir.

E. S. Yes, its probably a varicose ulcer.

(The eager and intelligent class cheered at this news, approached the woman and examined it closely)

Baby. Boo-oo-oo—wa-a-a-ow.

Mother (proudly), 'E thinks yo're a goin' for me, oh 'E's a knowin chap, he is, ai'nt yer ducky.

Baby. Yow—wow—oh-e-e-eee.

E. S. (Wearily to dresser). Is that case on the couch ready?

Dresser. Yes, sir.

E. S. I'll go and see it then (disappears behind screen, where by degrees he is followed by the eager and intelligent class, the woman thinking she is finished with, gets her things together and goes).

E. S. (Emerging from behind screen). Where's that woman with the ulcer?

A Patient. She's gone sir.

E. S. Gone—but—here B, run after, there's a good fellow, and bring her back.

B. Yes, sir. (Does so).

Papers by Guy's Men.

An Inquiry into the Primary Seat of Infection in 500 Cases of Death from Tuberculosis. By J. Odery Symes, M.D., and Theodore Fisher, M.D., M.R.C.P.—*British Medical Journal*, 16th April.

On the Action of the Blood Serum from cases of Acute Mental Disorder on B. Coli Communis. By Alice V. Johnson, F.R.C.S.I., and Edwin Goodall, M.D.—*Ibid*, 9th April.

Traumatic Rupture of the Small Intestine. By R. Lawford Knaggs, M.C., Cantab., F.R.C.S. — *Ibid.* Also :—

A case in which a Gall-stone was removed from the Gall-bladder, subsequent development of Malignant Disease of the Gall-bladder, death from Suppurative Cholangitis.— *Lancet*, 16th April.

The Cutaneous Affections of the Inebriate. By G. Norman Meachen, M.D., B.S., M.R.C.P., Lond.— *British Journal of Inebrity*, April, 1904.

Cases of Lateral Sinus Pyæmia. By William Sheen, M.S., M.D. Lond., F.R.C.S. Eng. — *British Medical Journal*, 9th April.

Appointment, Prize and Scholarship.

Assistant Demonstrator of Anatomy for months of May, June and July.—Mr. C. H. Rippman.

Winners of the Hilton Dissection Prize.—Messrs. K. H. Digby, E. W. Giesen, C. H. Rippman, *equal.*

Winner of the Scholarship in Dental Mechanics.—George Packham.

Guy's Hospital Dental Society.

A MEETING of the Dental Society was held on March 18th, the President, Mr. Maggs, in the chair. A paper on "Diseases of the Jaw" was read by Mr. F. A. Husbands, and in the discussion which followed, the President, Messrs. Dowsett, Mawer, and A. E. Williams took part.

"Casual Communications" were brought forward by Messrs. Bollard, Vine and Prideaux; that shown by Mr. Vine being of great interest, as it showed the unerupted upper wisdom tooth on each side, lying horizontally with its crown directed backwards. The President announced that the Annual General Meeting would be held on May 20th, and the meeting then terminated.

Sport.

CRICKET FIXTURES.

Saturday, May 7th.

G.H.C.C., I., v. Beckenham, away, 11 a.m.
II., v. Beddington, home, 2 p.m.

Wednesday, May 11th.

" I., v. London County C.C., home, 11 a.m.

Saturday, May 14th.

" I., v. R.I.E.C., away, 11 a.m.
" II., v. Old Golfeians, home, 2 p.m.

Wednesday, May 18th.

" I., v. Blue Mantles, away, 11 a.m.

Saturday, May 21st.

" I., v. Wanderers, home, 11 a.m.
II., v. Old Olavians, away, 2 p.m.
III., v. Camberwell House, away, 2 p.m.

LAWN TENNIS FIXTURES.

Saturday, May 7th.

G.H.L.T.C., I., v. Surbiton "A," home.

Wednesday, May 11th.

" I., Trial match, home.

Saturday, May 21st.

" II., v. St. Thomas's II., away.

POLO FIXTURES.

Wednesday, May 11th.

G.H.S.C., v. St. John's College, home.

Wednesday, May 18th.

" v. Nautilus II., away.

Change of Address.

Dr. G. W. C. Hollist, from Lodworth, Petworth, to 229, Balham High Road, S.W.

Dr. B. G. Neale, from The Grange, Westbury-on-Trym, to Heath End House, Cromhall, Gloucestershire.

Dr. J. Baynard Saundry, from 81, Greenwich Road, to 72, Blackheath Hill, S.E.

Dr. John Tanner, from 19 to 18, Queen Anne Street, Cavendish Square, W.

Dr. Arthur S. Taylor, from Douglas House, Surbiton Hill, to Lovelace Lodge, Lovelace Road, Surbiton.

Dr. L. E. V. Every-Clayton, from Emsworth, Hants, to Rosslyn, Clevedon, Somerset.

Dr. J. W. Gromitt, from 25 to 68, Constantine Road, Hampstead, N.W.

Dr. W. G. Thorpe, from 34, Bedford Hill, Balham, to Cleveland House, 270, Balham High Road, S.W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Appointments.

Civil.

DURHAM, H. E., M.B., F.R.C.S., has been appointed a member of the State Medicine Syndicate to conduct the examination for the Diploma in Tropical Medicine and Hygiene, University of Cambridge.

ECCLES, HORACE D., L.R.C.P., M.R.C.S. Eng., has been appointed a Public Vaccinator for the District of Tauranga, New Zealand.

Naval and Military.

Staff-Surgeon C. M. BEADNELL, R.N., and Staff-Surgeon S. E. KELSEY, R.N., have been appointed to the *Erebus* and *Melampus* respectively.

The following officers have been appointed to the command of station hospitals in the hills during the hot season in India:—

Major G. T. Rawnsley, R.A.M.C., Kuldannah.

Captain W. Beyts, R.A.M.C., Solan.

Solution of Case for Diagnosis.

(Published in GAZETTE of April 9th (W. J. T., æt. 37).

Post-mortem, March 31st.—

Adherent pericardium.
Fatty infiltration of heart muscle.
Dilated triscupid orifice.
Pleurisy at right base.
Follicular colitis.

Notices.

GUY'S HOSPITAL MEDICAL SCHOOL
(University of London).

GORDON LECTURES IN EXPERIMENTAL PATHOLOGY.

A Course of Twelve Lectures will be delivered during the Summer Session, on Thursdays, at 4 p.m., in the Physiological Theatre, by the Gordon Lecturer, A. E. BOYCOTT, M.A., M.B., B.Sc., Oxon.

SYLLABUS:—

May 12th, Methods. 19th, The Anæmias. 26th, The Anæmias, *continued*. June 2nd, The Anæmias, *continued*. 9th, The Symptoms and Metabolism of Anæmia. 16th, The Leucocytes. 23rd, Leucocytoses. 30th, Leuchæmia. July 7th, Ankylostoma. 14th, Ankylostomiasis. 21st, Some other Intestinal Parasites.

These Lectures are open to Students from any of the Medical Schools of the University, and to members of the Medical Profession.

HERBERT L. EASON, *Dean*.

Births.

HENDERSON.—On April 16th, at Kensington Square, the wife of Edward Erskine Henderson, F.R.C.S., of a daughter.

JAYNES.—On April 14th, at 159, Jamaica Road, S.E., the wife of Victor A. Jaynes, surgeon, of a daughter.

MARSHALL. — On April 22nd, at Vernon House, Huddersfield, the wife of William Lawrence Wright Marshall, of a daughter.

PENROSE.—On April 24th, at Highbury New Park, N., the wife of A. W. Penrose, M.R.C.S., L.R.C.P., L.D.S., of a daughter.

TULK-HART.—On April 23rd, the wife of T. J. A. Tulk-Hart, M.D., B.S., of 4, Gloucester Place, Brighton, of a daughter.

Marriages.

PARAMORE—GODSON.—On April 14th, at Christ Church, Woburn Square, W.C., Richard Horace Paramore, M.B. Lond., M.R.C.S., L.R.C.P., to Lilian Mabel, the youngest daughter of the late Rev. Edwin Godson, M.A.

WILBERFORCE-SMITH—COCKSHUT.—On April 19th, at St. George's Church, Brondesbury, by the Rev. R. E. Welsh, M.A., assisted by the Rev. W. K. H. Macdonald, M.A., Douglas Wilberforce-Smith, M.B., B.S. Lond., to Alsie, daughter of John Cockshut, Esq., J.P., of Glenmore, Willesden.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 419.] MAY 21, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	201–203
Gastrostomy in Cancerous Stricture of the Œsophagus. Clinical lecture by Mr. Golding-Bird	204–209
Correspondence	210–211
Notes from Skin Outers	211–212
In Lighter Vein	213–214
Pass List	214
The Diagnosis and Treatment of Coma...	214–219
Sport	219–220
Appointments	220
From the Gazette's Special Pathologist...	220
Change of Address	220
Papers by Guy's Men	220

Passim.

THE Presentation Day of the London University is by no means the tedious function that many people imagine it to be; in fact, the University authorities, if they err at all, err rather on the side of brevity. Last Wednesday afternoon there must have been many people at the Imperial Institute whose chief wish was to hear a speech from the Chancellor, after the solemn business of presentation had been completed. But Lord Rosebery disappointed us all, from the silken-robed dignitary, high and lifted up, down to a humble, but myopic gentleman at the back of the hall; this latter's disgust was much the more complete owing to his having mistaken the murmuring voice of the reader of the Annual Report for that of his lordship. On such occasions as this we have become accustomed to hear speeches galore from indifferent orators, and to be denied even a few sentences from one of our greatest English speakers, when apparently he was unable to avoid such a contingency, was like nothing so much as a slap in the face. Alas! the enervating effect of that "lonely furrow!"

IT is a pity, however, that more men do not avail themselves of the opportunity of representing their Hospital at so important a gathering as this, more especially as the Vice-Chancellor of the University is himself a distinguished Guy's man. On this occasion the onus of representation seemed to have been left to a few sisters and possibly a nurse or two, and, while it would be difficult to find better or more fitting representatives, at the same time it would be well if this community's sense of duty were a little more evenly distributed.

ONE of the chief features of this great occasion was, as usual, the whole hearted enthusiasm of the ladies of Bedford College. It is an annual custom for as many students as possible from this institution to assemble on Presentation Day and to hail the appearance of their successful sisters with unstinted applause. There is no need of a programme to signify the particular Alma Mater that has produced each of these ladies. Is her appearance the sign for a general outburst of applause and of

> "... a clamour ...
> As of a new world Babel, woman-built?"

Then one may know at once that it is a candidate from Bedford College. The chief beauty of this phenomenon is the complete absence of anything approaching favouritism; from the M.D. to the B.A., all are precious in the eyes of the ladies of Bedford College.

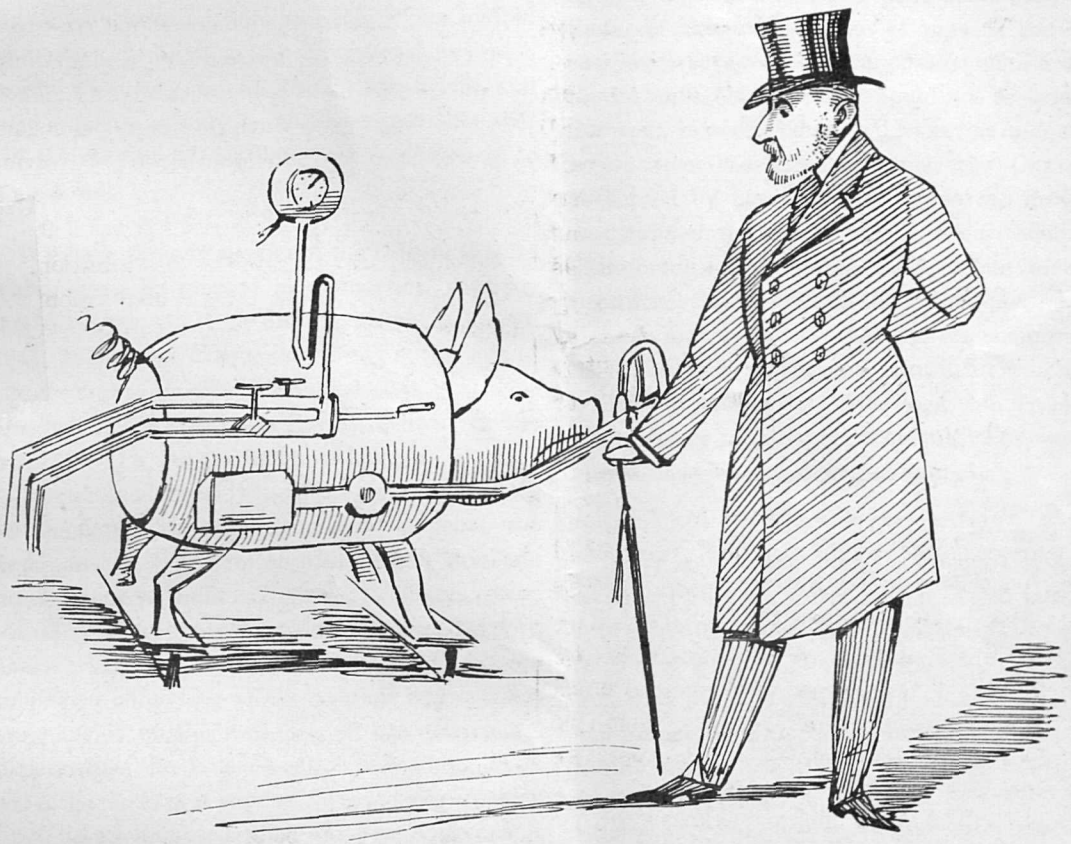
One is indeed inevitably led to reflect upon what Presentation Day might be like if every institution were to behave, proportionately, as enthusiastically as do these ladies. If, for instance, a strong contingent from every hospital was to be present, fired with the one idea of celebrating the prowess of its own men, then indeed it would be an inspiring scene, but one upon which the Chancellor and his colleagues would doubtless gaze with less of their customary academic calm. But so long as the military were not called in, the situation would be entertaining enough, and we recommend the idea to the consideration of all concerned.

In the retirement of Dr. Cock this Hospital has lost an old and valued teacher. The Dental Department in particular is the poorer by his resignation. Dr. Cock, with Dr. Silk, was one of the original anæsthetists appointed to the department on the formation of the Dental School in May, 1899. An eminently practical man, he laid himself out to teach; new methods and new drugs received a ready and adequate trial at his hands, and he brought to bear on his special work a ripe experience gained in general practice. He was exceedingly popular with the students, his Saturday morning "dems" being a special feature in the days when the revision classes for the L.D.S. were less elaborate than they are now. The Chapel clock might have been regulated by his weekly arrival, and it is a fact that during his fifteen years' service he only missed five attendances. The case-book in the Gas Room is full of interesting observations by Dr. Cock and of records of phenomena exhibited by patients under anæsthetics, and these would well repay the trouble of classification. Both his colleagues on the staff, and students, both past and present, will unite in their regrets that so tried a counsellor and friend should at last have left us.

In the old Operating Theatre on Monday afternoon last an interesting demonstration was given by Dr. Chapman on Dr. Raphael Dubois' new method of administration of chloroform. As a result of long experience in the physiological laboratory Dr. Dubois has succeeded in evolving an apparatus by which chloroform can be administered in the percentage of from ·99 to 2, uninfluenced by variations in respiration. We hope to publish an illustrated description of this instrument in our next issue.

The Advanced Course in Physiology at present being held at this Hospital is a great opportunity for all those who are anxious to pursue their study of this subject further than they have hitherto been able to do. The excellence of our Physiological Department and the interest taken in Guy's by the lecturers for the course have alone made this innovation possible, and it is to be hoped that many will avail themselves of the chances it presents. If a good attendance is secured at the lectures and demonstrations, the course, which is entirely a voluntary one, will be continued permanently.

Several complaints have been made of late of the growing tendency there is amongst some men to talk in the Wills Library, to the annoyance of those who go there to read. There should be no need whatever to point out that the men who do this are not only guilty of bad form, but are also behaving abominably selfishly. The noises in the neighbourhood of the Library are of a varied description, but, generally speak-



A Judge of Live Stock ?

[This was sent without any signature or title. It may represent the King at the Cattle Show, or Mr. C—— L—— inspecting the sterilizer in the New Operating Theatre. Anyhow, it is very badly drawn and we disclaim any responsibility regarding it.—Ed.]

ing, they are not very distracting; the human voice, however, is quite another thing, and it is particularly hoped that in future these conversations will be discontinued.

It is proposed that a section of the Wills Library shall be set aside for books written by Guy's men, and already the Librarian has a good number of these in his possession. All Guy's men (both authors and others) are invited to make a present to the Library of any such works that may be on their bookshelves and with which they may be willing to part, for that the list may be a complete one is obviously to be desired.

We have already spoken of the lecture theatre which is to be erected in connection with the new museum, but it may not be generally known that the present "squash" court is the site of the proposed theatre. "Squash" is not to be allowed, however, to die a violent death at the hands of the pure educationalist, for a space has been fixed upon behind the swimming bath, where it will be possible to build at least one and possibly two new courts. Upon this last point there is some division of opinion, some thinking there is not sufficient room for two courts; and certainly this is the case if each is to be the same size as the present courts; but we have it on the authority of the "squash" experts that the present one is in reality a little too large, so that it is possible that this difficulty may be surmounted after all. In any case it would be well if those most interested in the game would let the authorities know their collective opinion on this subject, for the workmen will commence operations in a week's time from now, and when once these have begun it will be impossible to make any alterations.

Also it is now definitely arranged that when the new museum has been completed the present building will be demolished *en bloc*, and the open space which will thus be acquired will extend as far as the dissecting room.

In another column will be found a letter from a correspondent who wishes to know the rules under which the Tug of War Cup may be competed for. We are in a position to state, on the highest authority, that technically the Sister of the ward, where at present the Cup resides, is supposed to be in possession of a book of the rules; but lest this should not be actually the case, it would be as well to say at once that, by the conditions under which the Cup was presented by Mr. Clement Lucas, the firms of Assistant Surgeons are not eligible to compete. The fortunes of the Cup seem of late to have been somewhat obscured, but we believe we are right in saying that the Externs once competed, or if they did not actually compete, they came within an ace of it. This was due either to ignorance or to a disregard of the rules, and in either case is to be deeply deplored.

If by any chance there is a peculiarly heavy Assistant Surgeon's firm, we mean that is to say a firm of men who are of exceptionally good physique, we would suggest (humanly speaking) that they pull the winners for sheer love if they can induce them to join issue, and (the question having been settled) that they leave the laurels to the vanquished.

The Gazette Prize Competition seems to have awakened enough interest to justify another venture into troubled waters. Accordingly we hope in a very short time to present our readers with another batch of quotations culled this time from a more modern poet. The quotations will be possibly easier to fit to the various people, and will be as politely appropriate as were those of the Shakespeare Competition.

Gastrostomy in Cancerous Stricture of the Oesophagus.

CLINICAL LECTURE BY MR. GOLDING-BIRD.

November, 1903.

GENTLEMEN,—In the last two and a half years we have had in Luke ward five cases of malignant stricture of the œsophagus, with resulting dysphagia, each case calling for surgical interference; and I propose making these cases the foundation for a few remarks upon the best way in which surgical relief should be afforded.

The general symptoms of the affection, I take it, you are familiar with; but I would remind you of one or two fundamental points, — anatomical as well as surgical—that you would do well to bear in mind.

The œsophagus, commencing at the cricoid level, does not maintain a vertical course as it passes down; but inclining to the left, it gradually reaches the median line at the fifth dorsal vertebra, and then again, with a bias to the left, it passes to the diaphragm, piercing it at the 10–11 dorsal vertebræ.

From this it results that in auscultating the œsophagus, during deglutition, in a doubtful case of stricture, the ear should be placed to the left of the spine; yet where thoracotomy is done for the purpose of reaching the posterior mediastinum, even though it be to explore the œsophagus itself, the right side is usually chosen, as it takes the surgeon rather further from the descending aorta. At its extremities the œsophagus is constricted, and its immediate surroundings are more rigid than elsewhere; but at the level of the fifth dorsal vertebra, it is again compressed between the root of the lung and the spine, whilst here also it is crossed by the aorta.

Putting aside the known likelihood of epithelioma appearing where sharp changes in structure occur, as at the ends of the œsophagus or the edge of the lower lip, the share that injuries may have in predisposing to the disease is clearly more likely to assert itself where there is greater liability to traumatism; and hence in the œsophagus, not only at the extremities but also in the middle, carcinoma usually occurs, for here it is that foreign bodies are likely to be delayed and to cause injury; but this is a subject we fully discussed last year when speaking of a case of impacted denture.

Though sometimes annular in form, yet epithelioma, at any rate by the time the surgeon has to interfere, is much more extensive, not only in sense of length of œsophagus involved, but of the surrounding tissues. At the cricoid level, therefore, laryngeal symptoms, due to hyperæmia, spasm, actual infiltration are seen, and the pain on deglutition is so very severe, that though a reasonable passage may yet remain, the patient will fail to swallow anything. The growth in time may open up either trachea or larynx, and at the fifth dorsal level the bronchus may be similarly involved, as in case 4; whilst anywhere in the chest the posterior mediastinum may be occupied by growth, and indeed the œsophagus may be all but unrecognizable, whatever passage is left being channelled in a mass of epithelioma.

I draw your attention to these points to emphasize the fact that should you use any form of probang for the purpose of diagnosis, the possibility of its being passed through the growth into the respiratory passages or into the mediastinum, or even the aorta, must be borne in mind, for I have observed that when once the bogey of aneurism has been disposed of, not much anxiety seems to exist as to the possibility of the instrument doing other harm.

The implication of lymphatic glands in cancer of the œsophagus is frequently confined to the mediastinum, and we know nothing of it; but the lymphatics of the upper part of the œsophagus go also to the lower deep cervical glands, hence a hard enlarged gland at the root of the neck, with nothing evident to account for it, should make the surgeon always inquire for any symptoms suggestive of œsophageal growth, and sometimes a very large glandular mass is met with when œsophageal symptoms, though evident, are very slight; for here, as elsewhere, the degree of implication of the glands bears no proportion to the extent of the primary growth.

I now give you a short résumé of each case, reserving till later, however, an account of the operations and the reasons for performing them:—

CASE 1.—Alfred C., æt. 58, Luke ward, 17th July, 1901, to 11th August, 1901. Reported by Mr. Mann. Dysphagia six months. Pain at suprasternal notch on deglutition. No solids taken for the last month. Bougie was passed by dresser in the surgery; great dyspnœa resulted, but patient able to swallow a few drops of liquid afterwards, a thing he could not do immediately before. Franck's gastrostomy performed on July 19th. Tube worn for nine days continuously when a little gastric fluid leaked by side of it, "burning" the skin. Tube removed, and patient instructed only to pass it at

meal times—otherwise to wear a pad and bandage. There was no more leakage, and the patient was discharged on August 11th, able to attend to himself, and with no leakage or excoriation.

Case 2.—Wm. B., æt. 63, Luke ward, January, 1902, to February, 1902. Reported by Mr. Maybury. Dysphagia three months. Liquids only taken the last two months. Much wasting and cachexia. Pain on deglutition opposite the third costal cartilage. A hard lymphatic gland in the right subclavian triangle. Position of growth diagnosed at about fourth or fifth dorsal vertebra. No bougie passed. Witzel's operation performed on January 27th. The stomach in this case was small and contracted. Tube worn continuously for 10 days, then passed only at meal times. No regurgitation at any time. Patient discharged on February 22nd, after being in for one month, able to feed himself in comfort.

Case 3.—Will. A., æt. 50, Luke ward, June 11th, 1902, to July 9th, 1902. Reported by Mr. Cheyney. Dysphagia six months; and all the time much troubled with regurgitation of food. The last month practically all he took was returned; he could always tell if any liquid happened to reach the stomach. Wasting rapidly, but no pain, only intense hunger. No growth in neck; presumed position of stricture was mid-dorsal. Witzel's operation performed on June 14th, and when discharged after five weeks there had been no regurgitation and the patient could feed himself. It is not stated how long the tube was worn continuously but it was discontinued some time before his discharge. In this case the patient suffered much from thirst, and both before and after operation; it was much relieved by the aid of normal saline rectal injections.

Case 4.—Hugh F., æt. 58, Luke ward, October 12th, 1903, died November 23rd, 1903. Reported by Mr. Ockwell. Dysphagia four months. Had been treated elsewhere with bougies for ten days and had taken only fluids from the time the dysphagia commenced. Pain on deglutition opposite the manubrium in the middle line. On swallowing milk a severe attack of coughing and some dyspnœa resulted, loud râles were heard, and frothy mucus, mixed with milk was expectorated. The growth had evidently involved a bronchus or lower end of the trachea. The patient was very ill, wasted and prematurely aged. Witzel's operation was performed on October 15th. The patient nearly succumbed to the anæsthetic owing to the embarrassment caused by the fistulous communication with the bronchus. Though primary union followed and the patient's condition improved, and though he was fed regularly, he gradually sank, dying from lung complication in five weeks (November 23rd). He never left his bed. There was, however, no regurgitation of food, and during the last few days of life the wound, which had healed, broke down and became septic. The autopsy confirmed the diagnosis of mid-œsophageal epithelioma, opening into the bronchus.

Case 5.—John M., æt. 47, Luke ward, October 13th, 1903, to November 19th, 1903. Reported by Mr. T. F. Wilson. Dysphagia for six months and had been under treatment by drugs at another hospital all the time. When admitted into Guy's he could only swallow liquids with great difficulty. Pain very severe on deglutition, referred to neighbourhood of cricoid cartilage and running up into the ear. Thickening could be felt behind the cricoid and an enlarged gland a little higher up. Voice thick and altered, and a swelling, with much hyperæmia, could be seen in the larynx by laryngoscope. A small bougie had been passed into the stomach but not retained. The patient was pale and anæmic but not ill-nourished. On October 15th, Witzel's gastrostomy was performed. Primary union was obtained, but an endeavour to employ the tube (after an interval of ten days) solely at meal times failed, for the extremity of the passage, where it perforated the stomach wall, contracted rapidly, so that a soft Jacques' catheter had to be constantly worn, and through it the patient fed himself. On his discharge he was perfectly comfortable and there was no regurgitation, the surface of the skin around the opening being normal.

Taken together these five cases illustrate, apart from treatment, which I will take last, some points of clinical interest.

Thus, all were men, and this is what is usual, women being but rarely affected; then their combined ages average fifty-five years, and these two facts are of great help in diagnosis, for dysphagia in a man over fifty years of age is almost certainly of malignant œsophageal origin. You will also note, that though in one a bougie was passed before we saw the case, yet this means of diagnosis was, I considered, unnecessary, and might possibly have been harmful, collateral facts sufficing for the correct reading of the case.

The dysphagia was generally dated back from three to six months, whilst the pain complained of was variable. This was most severe in case 5, where the disease was at the level of

the cricord; the pain on deglutition being both local as well as referred to as a cutting pain in the ear; the voice, too, was altered. In one there was no pain, except that of hunger, but the other three all had pain on deglutition over the upper part of the sternum, a level corresponding with the 4—5 dorsal vertebræ, where the disease was located. The pain of disease in this situation is sometimes referred to the right of the sternum, at the second or third intercostal space.

Microscopic examination of anything expectorated is very unlikely to help in a case of doubt; of more value is discharge or blood adhering to some instrument that has been passed; not that this is likely to shew epithelial cells of any diagnostic value, but if pus cells and debris are seen, we have the strongest possible presumptive evidence of carcinoma, provided the patient is over forty-five years of age. The only other likely intrinsic cause of stricture would be fibrous contraction after some ulceration or other breach of the surface, but this would not give present evidence of ulceration in pus and débris. To this extent, therefore, the microscope may prove useful.

Auscultation of the œsophagus in the position already indicated is a great help in determining the presence of stricture. The patient is directed to hold a teaspoonful of fluid in the mouth and to swallow it at a given signal, and the surgeon's ear now suitably placed behind, should detect that the œsophagus makes some two or three peristaltic efforts to drive the liquid down, instead of only one as in health. But here a fallacy awaits you; if you allow the patient to take a mouthful and not a teaspoonful, he may not dispose of it at one gulp, and then the reduplicated sound—though certainly not the same as when there is stricture—may lead to a false conclusion.

By such methods as these may your diagnosis be made; and my advice to you is, keep the passage of instruments for such cases where you feel you must have confirmatory evidence. In speaking of the treatment of malignant stricture by bougies, you will further gather my views as to its inadvisability even for diagnosis.

Primary union resulted in every case; and considering the complex character of the Witzel method it seems a little strange; also the continuous sutures employed to involute the stomach wall never gave any trouble.

Take any one of the cases I have read, and imagine him presenting himself for relief. What are you to do? Personally I am not in favour of treatment by dilatation, though occasionally one's hand is forced by the patient and it has to be adopted.

With carcinomata in general you endeavour to protect them from irritation and injury. The former produces hyperæmia, which means augmented pain and growth; the latter means hæmorrhage and sloughing. Now a bougie in a cancerous œsophagus does each and all of these things, and I have no hesitation in saying that an early gastrostomy prolongs life far more than the wearing of tubes. Some years ago I saw much of this latter in the hands of the late Mr. Durham, whose line of practice it was; I also gave it a trial, but in every case the result was that in time, from a fortnight and onwards but never long, the presence of the bougie or tube caused local sloughing, the breath became very offensive and foul discharge was retained in the mouth, and then septic broncho-pneumonia closed the scene. Towards the last the tube cannot usually be worn, nor can the patient by this time swallow; it is most distressing to be unable to relieve his sufferings, for rectal feeding is but a poor comfort.

The œsophagus tube passed, must be flexible, and adapted to the size of the stricture, it can be a long tube protruding from the mouth or nose, or a short tube, such as Mr. Symonds introduced. The long tube can be passed, on occasions, just for feeding, but this plan is not good; it will not be long before the irritation causes swelling and prevents your passing the instrument; if therefore you intend to adopt this plan of treatment, retain the tube in situ. When the growth is in the neck, the wearing of the tube is practically negatived, for it lies between the firm cricoid in front and the spine behind, and the pain and spasm it causes cannot be endured. This especially applies to the short tube, whose funnel-shaped end is particularly objectionable in this situation.

Below this point the short tube can be worn, but its place of election is undoubtedly in the mid-dorsal region. You are all familiar with this short tube, it is a 6-inch funnel-ended tube and the funnel end both prevents it slipping through the stricture, and catches the fluid food that has been swallowed, the patient by its means being able to get the flavour of his meal, and last, and by no means least, to swallow his saliva.

Admirable though these tubes are in non-malignant cases, I do not care to employ them in malignant stricture; some of my colleagues, however, use them; you will therefore be able to study their effects for yourselves. You must

remember that you cannot always have your way in treatment, and you may find you have to intubate against your will; but at any rate you will now know what you may expect as the case goes on.

Of all parts of the alimentary canal the œsophagus least lends itself for removal of a carcinoma. In the neck as part of a laryngeal excision it has been done, and attempts have been made to reach a dorsally-placed growth by thoracotomy into the posterior mediastinum, but though this is a legitimate route for removal of impacted foreign bodies, it is not of service—though the attempt has been made—for removal of œsophageal cancer.

The only operative measure I can advise you in these cases is that of gastrostomy; and once the diagnosis is made, the earlier the operation is done—in my opinion—the better, as life will be proportionately prolonged, and only occasional strain by deglutition need be put upon the diseased area, just to please the patient's palate, the main sustenance being taken directly into the stomach. In practice, however, we almost always do the operation when the patient is nearly *hors de combat*, and we can hardly blame him—perhaps any one of us would after all only give our consent just at the last. In this, as in other incurable affections, the time for the palliative operation is most usually determined by other than its own intrinsic value; but I feel sure in cases of malignant stricture of the œsophagus, if it is urgent that the life, for social reasons, should be prolonged to its utmost spell, this is best induced by as early a gastrostomy as possible.

Gastrostomy has a special interest for us as Sir Henry Howse first performed it here many years ago, and the method he employed was long in use.

The aim of the operation was merely to attach the stomach to the parietes at the edge of an opening made either parallel with the ribs, or vertically through the rectus muscle on the left side. The visceral peritoneum was sewn to the parietal, so that an area of stomach was exposed averaging one by half an inch. After a day or two, when adhesions had firmly formed, the stomach was incised and the patient fed. No tube was continuously worn, even for a short time, since such a wound into the stomach shows no tendency to close, but a rubber tube, with funnel attached, was passed on each occasion of feeding. In this respect this method could claim one advantage over those I am going to mention and recommend, in that quite a large incision could be made into the stomach, so that the tube employed could easily take some solid food; but its drawbacks that I am about to mention quite outweigh its advantages.

We were not so familiar with the formation of peritoneal adhesions when this operation was devised as we are now, hence the delay in feeding the patient; but nowadays, were this operation performed, I do not think we should hesitate for a moment to open the stomach at once were it necessary. I may, however, remind you of a very simple way of feeding quite safely, should, for instance, the state of the patient require that you should administer food even while operating. It is to pierce the stomach with a hollow aspirator needle, to which a funnel or syringe has been adapted and through it at once to give a stimulant or whatever liquid food you desire. Once in performing gastrostomy in an all but hopeless case, I was at least temporarily in this way able to recover my patient from a severe condition of collapse.

The drawback of this form of operation is the impossibility of preventing leakage from the stomach, with the consequent digestion of the skin around the opening. For the problem, as you see, before the surgeon is to fix the stomach to the parietes and make a hole in it for feeding purposes, and at the same time to provide some sort of sphincter-action to prevent any regurgitation. This regurgitation is not serious from loss of food, but the acid chyme escaping rapidly digests the surface of the skin around, producing a raw and coarsely papillated surface that is cruelly painful.

Unfortunately this was too often the case in the above method of gastrostomy. Pads were useless to prevent it, though in combination with some alkaline earth, such as carbonate of magnesium, considerable comfort was given and annoyance saved. Yet, all said and done, the results were not ideal, and I feel sure that this had much to do with gastrostomy, not being altogether popular with the profession, except as a last resource. This reproach is, however, now removed, and we have a choice of methods, any one of which will guarantee the patient against this serious drawback, and affords the strongest argument for early operation.

The various minute operative details you can read in your text books; I shall only deal, therefore, with the principles and relative merits of the different methods. Attempts to obtain a sphincter action in its true sense, by working through a vertical incision in the rectus abdominis are not successful, although affording better results than an incision through the linea

semilunaris. A muscle without suitable nerve arrangements is useless as a sphincter, surgeons therefore have had to devise a physical and not a physiological way of overcoming regurgitation, and the three operations, Franck's, Witzel's, Kader's, all fulfil this requirement. The two first were done in the cases I have read to you, the last I have not performed, nor do I think I am likely to do so, so perfect do the other methods seem.

The surgeon is not always sure until the belly is opened, which operation he can perform, since the size of the stomach limits his choice. Where the stomach is practically of normal size he can perform either Franck's or Kader's, but where it is shrunken to the diameter of the colon, he must choose an operation which does not require a large surface for work, and Witzel's operation here comes in. Other things being equal, the longer gastrostomy is delayed the smaller is the stomach likely to be.

To avoid repetition I may here say, that in each operation the wound through the parietes starts about one inch below the costal margin and is carried vertically downwards for three to four inches, through the thick of the left rectus muscle, and so into the peritoneal cavity. If now the stomach can be drawn well out of the wound any one of the three operations can be performed, but if this is not practicable then Witzel's operation must be performed, after taking all care to pack off and protect the surrounding peritoneum.

In case 1 Franck's operation was performed. A cone, some three inches high at least, was pulled up from the anterior gastric wall and brought out at the wound. The base was now stitched round to the fibro-peritoneal layer, forming the posterior sheath of the rectus. The piece of skin intervening between the top of the incision and the costal margin (or a little higher) was now dissected up as a bridge, a short incision being made in it over the rib cartilages. Beneath this horizontal bridge or strap the stomach cone was now pulled and its apex made secure in the upper short incision. It is even better to split, on the flat, the upper fibres of the rectus, so that some muscle fibres, anterior rectus sheath, subcutaneous tissue and skin, form this strap.

The original laparotomy wound was closed in the usual way and all that was now seen was the tip of the stomach cone protruding through the highest incision. After an interval of twenty-four hours the tip of the cone was opened and a feeding tube passed into the stomach and a liquid meal given.

You will observe two special points in this operation, one is that the cone drawn up from the stomach is lined with mucous membrane throughout, it has therefore no tendency to contract, and when once the parts are healed the feeding tube need only be inserted at meal times; the other is that regurgitation is prevented by the oblique position of the cone, and its compression underneath the strap or bridge of skin and also by a pad against the cartilages of the ribs. It might seem that as the mucous membrane reaches right up to the skin, sufficient moisture would escape to corrode or digest it around, but I have not observed this to happen. It is important not to retain the feeding tube (which may have an outside diameter of a No. 14 English catheter) longer than necessary, as some regurgitation may then take place by the side of it. In our case (case 1) the tube was kept in for eight days, after that it was passed only at meal times.

In all the other cases (2–5) I performed Witzel's operation, and the results were quite satisfactory.

In this operation a tube is, as in Franck's, constructed out of the anterior wall of the stomach; but it is lined with peritoneum and not with mucous membrane. Where a cone of the stomach can be pulled well out of the wound the area to be operated on can be first isolated by being stitched to the parietes, but this is not absolutely necessary; nor is this even possible in the case of a small and very contracted organ.

A spot selected on the anterior wall is first punctured so as to admit the end of a large catheter or tube, which if stiff must have had the tip bent to a right angle in hot water previously. The bent tip now being passed into the stomach, the stem of the catheter will be on the anterior wall, in a direction pointing upwards and toward the left. A Lembert suture is now put in in such way as to fold the sero-muscular wall of the stomach completely over about two inches of the catheter, including, of course, the point where it enters at the puncture.

By this means the end of the catheter is embedded in the anterior stomach wall, and the tube or passage thus formed of the sero-musculature is attached at its left or emergent end by a stitch to the parietes and, if possible, to the skin itself. Regurgitation is effectually prevented by the shape and position of this passage, for there is no bridge or strap of skin beneath which it is compressed as in Franck's operation. The passage being lined with endothelium should be more likely to form adhesions

and contract, or even close, yet, in practice I have but once found it so. In case 5, a contraction did, however, take place just at the entrance into the stomach, and necessitated, as I have mentioned, the constant wearing of the tube. I am unable to say why this should have been, as the operation was performed exactly the same in each case. This liability to close has caused the suggestion to be made that if for any temporary purpose gastrostomy were performed, Witzel's operation should be chosen, as the opening would be likely to close of itself if left alone when no longer needed.

The length of time the catheter or tube should be worn continuously seems to vary with different surgeons. For fear of contraction, some surgeons say for two months; my shortest time was ten days. In two the time is not noted, but as the patients left in four to five weeks *without wearing their tubes—only* passing them for meals—they were certainly not worn after twenty-one days; and I know of other instances where the continuous wearing of a tube was dispensed with in five days. If we take the mean of all these and say that the tube should be worn straight off for about twenty-one days, we shall probably be not far wrong.

Witzel's operation is thought by some to be unsuitable where the patient is much exhausted as it takes a little longer to perform than Franck's, but the difference is so slight that I do not take it into account; besides, there are some cases in which, as I have said, Franck's cannot be performed, and it is just in these with contracted stomachs you are more likely to meet with serious exhaustion; yet, you must either do a Witzel or merely stitch up the stomach in Howse's way—a plan not now to be recommended at all.

Of Kader's operation, since I have no case to illustrate it by, I will only say that it also aims at producing a peritoneal passage for the catheter, not by sewing the stomach wall over, as I have related, but by a process of involution. Thus, a catheter is passed a short way into an opening made in the anterior stomach wall, and by a purse-string suture is firmly gripped there. If now the catheter be pushed onwards into the stomach, it involutes the wall with it; and when ¾-inch more has been thus involuted, it is sewn, in its turn, tightly round the catheter, which is again pushed on till some two inches of the wall have been involuted all together, and three or four inches of purse-string sutures applied. A tunnel or passage is thus formed of all the stomach coats, projecting into the interior of the organ, lined by peritoneum, its outer end being attached to the abdominal parietes. I cannot from experience claim any special advantage for this method, it certainly would appear unsuited to cases of very contracted stomach to which Witzel's operation is applicable, and if employed at all it would be as an alternative to Franck's gastrostomy; but personally I am very contented with the latter.

I have purposely avoided, gentlemen, going into such details as you can only learn by seeing the operations actually performed, nor are they suitable for a clinical lecture. My object to-day has been to take a broad survey of the surgical treatment of cancerous stricture of the œsophagus, and I may thus sum up what I have endeavoured to convey to you. In diagnosing cancerous œsophageal stricture, leave *instrumental—i.e., bougie—methods to* the last (if used at all), and rather make your diagnosis by other means; just as in a case of fracture, whilst it is very convenient and convincing to obtain the evidence of crepitus, yet it is, generally speaking, the last thing you should look for, and in some cases positively refrain from trying to obtain, since positive harm may result from so doing.

If life is to be prolonged to its utmost limit gastrostomize early; the objections to the earlier methods of performing this operation do not now hold good, for you can promise the patient freedom from the serious annoyance of regurgitation.

Treatment by tubes, whether with the view of dilatation or for feeding, or whether worn continuously or used on occasion, whilst it may prolong the patient's gastronomic enjoyments, will only hasten the progress of the disease and lessen your subsequent operative chances of success. You must, therefore, determine by a study of the merits of each case whether you will commence with it or not, or whether you will not from the first urge the advantages of gastrostomy.

But above all, the surgeon must on advising these palliative methods—operative or not—bear in mind that he is only giving the patient alternatives of relief; and since they are not cures, the patient, if an intelligent person, must and should be the final court of appeal to which the question of treatment is referred, social and personal considerations, at least in private practice, weighing as much, if not more, with the patient, than the advantages or the reverse of the most scientific and up-to-date surgery.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Letters from a G. P.

No. 2.

SIR,—In my last letter to you I had a small stone to throw at the teaching of our hospital. I should now like to award a wreath of laurel. Let us all be duly grateful that we are taught to be practical, and are weighted at an early period with some responsibility which makes us strong. I sometimes hear that the various appointments at Guy's are to be freed of some of their responsibilities, which would be to rob them of half of their value. The clinical and house appointments would be paltry without the right of "taking in."

One other great heirloom is good fellowship with the staff, generally spoken of as *esprit de corps*, an expression almost as trying as *entente cordiale*. Somehow or other we always seem to extract great credit out of this and after all it is only just as it should be. I am quite prepared to admit that we are on better terms with the staff than at any other place with which I am acquainted, but it is only one of the obligations of our particular society. Let us be quite frank about it and say that the benefit is mutual and not one-sided. We are all members of one profession, and the student has as much right to expect courtesy and help from the staff, as the staff to expect deference and support from the student.

It is essential for a man in general practice to know several consultants, whom he can call friends. Most of us eventually find our way into general practice sooner or later, though we do not face the position at first. All of us sooner or later find ourselves in a hole. This is apparently denied by some. The most charitable view to take of these latter is that they are unable to recognise a mistake when they make one. They continue in ignorance and never gain the confidence of a brother practitioner.

Having landed in a hole there are difficulties to face. You may crawl out quietly and unobserved if you exercise cunning. Perhaps the friends of your patient want a second opinion, which is never to be opposed, as no good can come of so doing. Do not do as one man I have heard of, who opposed it, and said he wanted all the "kudos," when a second opinion was suggested on an obscure and acute surgical condition of which the patient died. He got all the "kudos." If you have a consultant for a friend, now is his chance. No one wants to cover up your mistake at the expense of the patient's health, but the two things are not incompatible. A perfectly just and true judgment can be given, and yet the reputation of a man who has only erred through ignorance can be spared. Even if you are unknown to him, it need not be urged on the consultant like the miner, "Yon's a stranger, 'eave 'alf a brick at 'im."

I have heard of a doctor who lost a very good patient who developed a belladonna rash, because the consultant though it humour, when asked for his opinion, to reply, "Oh, ask Dr. ——, he knows all about it." Also it is recorded of one of our old time physicians that when the practitioner expressed his surprise at the discovery of a pericardial rub, the great man was condescending enough to say, "Oh, it is just as well, or you might have treated it." Such a man, however great, deserves no support from any practitioner.

We must face the fact that many reputed consultants are quacks and that some junior ones seem to have no sympathy with their fellow men. Therefore make friends with one of the many who abound in acts of kindness to their brothers in the profession, and even to the vast host of people who plead the sacred cause of charity. I remember that it was difficult to repress a smile at the hospital when told that Dr. —— said the patient was suffering from something obviously impossible. He very possibly said nothing of the sort, but even if he did, a sneer might be avoided. The G. P. is not quite so simple as we all imagine in our early days. There was trouble once I recollect over a patient who came up with a diagnosis of peritonitis, when the funny man was overheard to remark, "That she must have left it in the cab."

One cannot be too careful over such things at the hospital, and the laconic summing up of some clinicals in the formulæ of "No good to me," might be bettered if the patient's friends are within earshot.

All this sounds rather like the old advice, "You scratch my back and I'll scratch yours," but I venture to state, sir, that there are worse sayings to adhere to than this, which may at any rate enable us to live at peace with our fellows.—I remain, sir, yours faithfully,

WORLDLY WISEMAN, M.D.

"Worldly Wiseman" replies to his Critics.

SIR,—When I wrote my first letter to you I did not anticipate such a lashing as I received from "Fellow." His letter taught me many things. Firstly I am a "gross materialist." Once I acquired a "few catchwords" of psychology which "Fellow" tells us should be part of our equipment, and I can only admire the perspicuity of the writer, which enables him from my letter to deduce my state of mind so easily.

He goes on to imply that I am a sort of huckster, haggling for shillings and taking no pride in a good case, and is gracious enough to extend his pity. I cannot quite see how I should have been so misread. What I wished to say was, that there is a great danger of missing the whole aspect of a case in concentrating the attention on one part. Most people in the hospital know of a man of whom they will say, "Oh, he doesn't

know much medicine, but he can see when they are ill." This is the sort of low cunning which I am convinced was much better cultivated in the older generation.

"Fellow" glories in his use of the laryngoscope and the ophthalmoscope, and I daresay his frequent use of them brings him a reputation as a specialist. I did a fair amount of work with an ophthalmoscope, a good deal more than the average man, and only learned to mistrust my own judgment except on the simplest cases. The laryngoscope and its accessories are infinitely more useful in general practice, and I quite agree that every man should have a working knowledge of them, but on reading my last letter I cannot see that I mentioned the laryngoscope.

On the question of the teaching of prognosis I am quite opposed to "Fellow." In my time there was one H.P. who asked us all to make a prognosis over each case and then asked our reasons for it, and I am grateful to him now. We cannot all afford to spend two years at an infirmary, and some of us find it necessary to stew in the library, or we shall, to quote an authority, meet with a rebuff at the hands of that small but well armed tribe—the examiners.

I find that I said that prognosis was *the matter* of the greatest moment, and there "Fellow" seizes his chance, but I fancy "a matter" would have expressed my meaning, for prognosis cannot be put before treatment.

"Fellow" takes too much upon himself, and apparently poses as a sort of medical philanthropist. This is a standpoint which meets with well-deserved ridicule at the hands of a good many lay people. Was not the consultant in Little Mary amazed that a simple, innocent white envelope should contain a cheque? Like Poohbah, he may have said under his breath, "Another insult and a light one."

Let us clear our minds of cant and acknowledge frankly that we have taken up medicine not only as a profession, but as a livelihood, for that is the case with most of us.

Once I heard a doctor lament that someone never paid him, and an artist said with quiet sarcasm "Oh I thought reward was the last thing thought of in your profession," and such is what some would imply.

Enthuse by all means over a good case. I even do myself, although "Fellow" himself finds it difficult apparently and will allow me none of it, but enthusiasm is hard to raise over people who can and won't pay when one is trying to make a living.

Even "Fellow" seems to want to reap a reward, and after his diatribes against the sordidly commercial side of our profession and the constant affronts to a well-born man of sensitive disposition he mentions gratitude and as an after-thought *shekels*—of all things!

Oh "Fellow," Oh Poohbah, what a fall! What hope is there for most of us to escape being gross materialists when even a well-bred sensitive philanthropist, a man of high degree, glorying in pure love for his profession, clothed in his virtues like a mantle, expects to receive shekels. Ichabod, our glory is departed.—Yours, etc.

WORLDLY WISEMAN.

Tug of War Cup.

DEAR SIR,—I should be glad if you can give me some information with regard to the Tug of War Competition for the Cup presented by Mr. Lucas. After diligent enquiry I can find no one who knows whether there are any definite rules governing the contest, and yet I am told that an Assistant-Surgeon's firm is not eligible to challenge for the Cup. If this is so, surely it is diametrically opposed to all ideas of sportsmanship. The reason that an Assistant-Surgeon's firm has never entered before is much more likely to be because there has never been a sufficient number of men on the firm to form a team, than because there was a rule against their entering. Hoping you can enlighten me on this subject.—I am, yours faithfully,

"AN ASSISTANT-SURGEON'S DRESSER."

Notes from Skin Outers.

Ringworm.

Ringworm may occur in the following varieties:—

1. R. of the head (*tinea tonsurans*).
2. R. of the body (*tinea circinata*).
3. R. of the beard (*lycosis*).
4. R. of the pubic and axillary regions (*eczema marginatum*).
5. R. of the nails (*onychomycosis*).

Case of Ringworm of Body showing double concentric rings.

Ringworm is due to a *fungus*, of which there are two main groups, the small-spored (*trichophyton microsporon* and the large-spored (*trichophyton megalosporon*) ; of the latter again there are several varieties.

The *microsporon* is found in 90 per cent. of cases of scalp ringworm, at all events in this country, and probably is responsible for most of the cases of T. circinata (R. Crocker), although Sabouraud states that megalosporon is the most common form in the latter affection ; in England Sabouraud's observation only holds good with adults. Suppurating sycosis, according to Sabouraud, is always due to a variety of megalosporum, as is ringworm of the nails. Ringworm is very catching, and may be conveyed to man from man, or from domestic animals.

1. *Ringworm of the scalp* is essentially a disease of childhood, up to the age of puberty, and is most amenable to treatment about fourteen or fifteen ; of course a child suffering from it should be kept from school and as much as possible from other children. Although by no means always easy of diagnosis, a well-defined case presents the following features:—

a. It begins as a red papule around a hair, which soon forms

b. a round, well-defined, scaly patch

c. which, when larger, is distinctly thickened and of a dirty grey colour.

d. The hair over it is short and reduced to dull, broken-off stumps.

e. These stumps stick about in all directions, and show a want of the regular, set arrangement observable in the surrounding healthy hair (like a field in which a cow has been tethered [Norman Walker]). If these stumps are pulled out the roots are seen to be covered with a white sheath, which after soaking in Liq. Potassæ, B.P., for half an hour, can be seen to consist of a mosaic of round spores—the mycelium has penetrated into the shaft of the hair.

Kerion is a pustular form of scalp-ringworm, chiefly due to megalosporon, or possibly may be the result of treatment.

2. *Ringworm of the body* may occur alone or with one of the other varieties. It may form scaly, solid patches or, by clearing up in the centre, appear as rings, rarely as a double or treble concentric ring. The ring is raised and slightly papular. It increases centrifugally to the size of a shilling or a crown, when it remains stationary. Neighbouring rings may coalesce and form a gyrate figure.

3. *Ringworm of the axilla and pubis* being in a warm moist situation, favours the growth of the vegetable fungus, and is therefore accompanied by more inflammation. The border is distinctly raised and broad, and in hot climates is known as "dhobie itch," which may be very severe and obstinate. There is generally much irritation.

4. *Ringworm of the beard* causes itching, red round scaly patches or rings. It is extremely prone to become pustular, and is generally contracted by those who are shaved by barbers. As opposed to ringworm of the scalp it is naturally a disease of the mature-aged and not of the young.

5. *Ringworm of the nails* causes discolouration, splitting, ridging or longitudinal striation of the nails, and the diagnosis must be confirmed by the presence of the disease elsewhere or by microscopical examination.

Treatment.—Sir Cooper Perry teaches that in private practice, where the effects of applications can be carefully watched, vigorous methods should be adopted in the treatment of ringworm of the scalp. Thus:—

1. Cut the hair over affected areas quite short.
2. Wash scalp thoroughly.
3. Apply cocaine (10 per cent. solution).
4. Apply croton oil.
5. Put on a poultice at night.

Then use Ung. Ac. Boric or other soothing application. Instead of croton oil, Liquor Epispacticus or Collodium Vesicans may be prescribed. With hospital out-patients such vigorous methods cannot be used. Thus the ordinary paraciticide ointments must be tried, viz., Ung Hyd. Oleatis : Ung Acid Carbolici, or Ung. Chrysarobini.

R. Crocker recommends Ac. Salicyl. grs. 10, Collodion ʒj. painted on daily for a week after shaving the scalp, then the scab lifted off and the treatment repeated where necessary until the disease is cured.

Whatever treatment be adopted great perseverance is necessary.

Whatever variety of the disease may be presented, the same principle—*i.e*, the destruction of the fungus—actuates our rationale of treatment, but naturally extensive cases cannot be so vigorously attacked as more localised ones.

No case of ringworm of the scalp can be considered cured until, after careful search, no broken stumps of hair can be discovered among the fine downy hairs which follow a cure. The treatment may be expected to last from three months in recent cases to twelve months or more in chronic.

In *Ringworm of the body*, Ung. Oleatorum or Ung. Iodi may be applied. In "dhobie itch" Sir Cooper Perry has had excellent results with Ac. Salicyl. ʒj., Ung. Chrysarobini ad ʒj. p.a.

In *Ringworm of the beard* careful epilation is required in addition, or Ung. Oleatorum may be applied, with bathings of hot carbolic lotion at nights.

In the other varieties, commonsense will dictate the treatment according to the extent of disease, and opportunities for watching the patient. Finally, the application of X-rays, with the subsequent shedding of affected hairs, has been recommended and may be tried in obstinate cases where other remedies have failed. The writer has found this treatment effectual in the one case in which he has tried it, *i.e.*, in a case of sycosis.

In Lighter Vein.

POINTLESS FABLES.

[With apologies to R.L.S.]

There was a Ward Clerk once who had three beds, much spare time, and a good opinion of himself. He looked after his beds indifferently, manured his good opinion daily, and spent all his spare time playing snooker. And there came an Inguinal Hernia and occupied one of his beds.

So the Ward Clerk armed himself with a Guy's slip and a bland smile, and went bedwards to interview the Inguinal Hernia.

"What did your father die of?" asked the Ward Clerk.

"A kind of shortness of the breath, doctor," said the Inguinal Hernia, who was not well up in science.

"And your mother?" asked the Ward Clerk.

"Sort of same thing," answered the Inguinal Hernia. "Both of 'em."

"Really," said the Ward Clerk. "Any of your family dead?"

"Lord, yes, doctor," said the Inguinal Hernia. "Me brother-in-law died of an accident—knocked over by a cab a-coming out o' the 'Hole in the Wall,' doctor."

"Thank you," said the Ward Clerk, gratefully, and he went and entered in his report, "Family history—father and mother both died of shortness of breath. Brother-in-law killed by a cab accident. Otherwise good"—and fetched the screens for the Registrar.

When at last he carried back the screens the Ward Clerk paused and shook his fist at the Inguinal Hernia.

"—— you," said the Ward Clerk.

There existed a Genial Professor once, who knew much about internal secretions and little about his own consciousness, and who received a red ticket of admission to the annual meeting of the Anti-Vivisectionist Society from a Cordial Admirer.

"You'll go, of course," said the Cordial Admirer, and added, as an inducement, that Mr. Coleridge himself would speak.

"No," said the Genial Professor, "I shan't go. Joking apart, it wouldn't be physiological."

"Then you really don't believe in it?" asked the Cordial Admirer.

"Decidedly not," said the Genial Professor, with a serene smile. "If you will turn to the *British Medical Journal* and read the articles on Myxœdema——"

"I haven't time," said the Cordial Admirer, hastily. "The little brown dog——"

"Exactly," said the Genial Professor, "exactly. I might, of course, speak about that."

"Do," said the Cordial Admirer, "it would be so nice."

"But useless," said the Genial Professor, sadly. "They would not understand, you see. Besides, joking apart, it would not be physiological."

And he disappeared into his sanctum where he cut the red ticket into pointer slips for his muscle lever, and proceeded to record the movements of a frog which he had taught to croak "Ninety-nine."

Once upon a time they showed a Damper round the hospital.

"This is the new operating room," they said.

"Indeed," said the Damper. "Well, I can't say much for it. The light's bad. Now, at Milan you should see the operating theatres."

"We did a Cæsarian section last week," they told him. "How's that!"

"That's nothing," retorted the Damper. "At Tubingen they did three in one afternoon."

"There's the new museum," they said. "This is our old one."

"Jolly old, too," said the Damper. "These mica tops are out of date. At Montpelier they have screw tops, see?"

"Oh, come along," they said, and showed him the silver in the Smoking Room.

"There," they said.

"After all, it aint much," said the Damper. "At Harvard, now——"

Five minutes later they carried the Damper to the Front Surgery on a stretcher.

There was a Great Surgeon once to whom came a Perforated Gastric Ulcer in a state of collapse.

So the Great Surgeon did a laparotomy and sent him away much improved.

But in course of time the Perforated Gastric Ulcer came back with adhesions.

Thereupon the Great Surgeon did a gastro-jejunostomy and broke down the adhesions.

But the Perforated Gastric Ulcer came back a third time with more adhesions.

Which the Great Surgeon again broke down, and said it would do very nicely.

But once more the Perforated Gastric Ulcer returned with adhesions and worried the Great Surgeon excessively.

"Really," said the Great Surgeon, "it's too bad. You're not a surgical case at all. You must go to Stephen."

So thay carted the Perforated Gastric Ulcer to the medical wards, where in due time his history terminated with a Necropsy.

Pass List.

University of Cambridge, May, 1904.

DEGREE OF BACHELOR OF MEDICINE.

R. D. Smedley.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

S. Child, J. Goss, T. C. Lucas, W. M. Mollison, B. H. Stewart, G. A. Ticehurst.

Royal College of Surgeons of England. May, 1904.

FINAL EXAMINATION, LICENCE IN DENTAL SURGERY.

Parts I. and II.—F. J. Goodman, P. E. Luce, E. L. Pilbeam, H. Poyton, J. F. Ryder, H. J. Snowden, C. L. D. Taylor, J. H. Williams.

Part I. only.—W. J. Bollard, A. Hammond-Smith, F. A. Husbands, J. W. Mawer, F. S. Vine, W. J. Wormald, *W. H. Yeo.

Part II. only.—*R. J. Messent, *J. A. Oates, *H. A. Pallant, *H. E. H. Tracy, *A. E. Williams, G. E. Wood.

FIRST PROFESSIONAL EXAMINATION, LICENCE IN DENTAL SURGERY.

Mechanical Dentistry and Dental Metallurgy.—J. A. Bowes, C. M. Craig, W. J. P. Dicks, R. P. Fenn, T. Scott Foster, F. J. Gillett, E. D. R. Jacob, J. McBride, F. J. Messer, A. W. Parrott, C. L. Pemberton, W. H. Plowman, G. E. Rice, O. J. Roots, C. R. Rudolf, T. L. Smith, W. J. C. Timberlake, R. G. H. Warner, D. G. Wearing, H. J. Weighell, C. Weller, R. G. Yates.

Mechanical Dentistry only.—*A. R. Durant, A. E. Webb.

Dental Metallurgy only.—H. E. Alexander, W. T. Dean, B. B. Samuel, A. S. Thomas.

* Denotes completion of examination.

The Diagnosis and Treatment of Coma.

Awarded Physical Society's Prize.

A paper read before the Physical Society on Saturday, February 27th, 1904, by N. I. Spriggs.

Division I.

Mr. President and Gentlemen,—Nuttall defines coma as "a morbid disposition to sleep," whilst in Treves we read that "coma is a state of more or less complete insensibility." Though hard to define, most of us have a pretty definite idea of what we mean by a comatose person. A person who cannot be roused by *any* stimulus would generally be called "completely comatose," and in most forms of so-called coma, *e.g.*, diabetic, the patient can be roused to a certain extent.

In this paper I have included under the term, all cases of partial coma in which the patient can be roused with difficulty.

I have not usually included those cases in which the patient is described as "dazed" or "sleepy."

Coma ends the scene in a large number of diseases, and it is obvious that they cannot be included in a paper such as this. Therefore I have only considered those injuries or diseases which give rise to a more or less sudden coma, in which the patient may become comatose whilst about his ordinary duties.

With the view of estimating roughly the frequency with which the various forms of coma occur, I have looked through one year's reports, medical and surgical, of all cases of sudden coma in this hospital, so that any man here will have a moderate chance of seeing each of the forms of coma described below. My headings will be as follows:—

Firstly.—A short text-book description of each of the more common causes of coma. After each, some allusion will be made to the cases of that nature in the year's reports, and to their frequency.

Secondly.—Diagnosis: the most reliable symptoms in the order of their practical use.

Thirdly.—Allusion to a few cases not diagnosed or incorrectly diagnosed.

Fourthly and lastly.—Treatment.

Apoplexy.

1. *The mode of onset varies:*—
   (*a*) It is most often ingravescent; going on to coma, say, in half an hour; perhaps with pain in head, collapse, vomiting and slight convulsions.
   (*b*) Often it is quite sudden—the typical "stroke."
   (*c*) Motor power may fail before coma comes on. This onset is more typical of embolism.
   (*d*) Vomiting or convulsions may be the most marked sign.

Rarely a history of prodromata in the shape of sensory or motor disturbances can be obtained. Nearly always there has been a previous attack. In the only two cases

which I have observed whilst the hæmorrhage was actually taking place, in one the patient became collapsed with vomiting and stertorous breathing and died in about a quarter of an hour; in the other he was immediately seized with convulsions, bilateral, and died in two minutes. This was probably due to the hæmorrhage being in the lower parts of the brain, as convulsions are then more common.

2. *The patient* will probably be a stoutish man over 45. The face is generally congested, but may be ashy grey. Hæmorrhage may also occur in younger subjects in acute fevers, in the anæmias, or after embolisms.

3. The *pulse* is typically full, slow, and of increased tension.

4. The *temperature* is nearly always subnormal at first, and rises more or less suddenly. It may be very high in very large hæmorrhages, or in pontine hæmorrhages, or just before death; and hyperpyrexia has also been recorded in hæmorrhage of the anterior cerebrals, or into the corpora striata. The temperature on the paralysed side is typically higher, with increased sweat.

5. *Hemiplegia* is often found, or monoplegia, and if crossed hemiplegia is found, it is diagnostic of cerebral hæmorrhage, embolism, or thrombosis. Rigidity in anæsthesia may also occur, and be uni- or bi-lateral.

6. *Reflexes.*—The superficial ones are absent. The deep increased, especially on the paralysed side.

7. The *respirations* are stertorous, or perhaps irregular, or of Cheyne-Stokes character.

8. The *eyes.*—The corneal, conjunctival, and light reflexes may be present or absent, according to the depth of coma. The pupils may be in any condition. *Conjugate deviation* occurs towards the lesion in paralytic cases of capsular hæmorrhage, or in the opposite direction in pontine hæmorrhages. If convulsions occur, these directions should be reversed.

9. The *sphincters* are generally relaxed. The heart will be hypertrophied, the urine often albuminous (slightly). Cirrhosis of the liver may be found, and the special senses may be affected.

In the Reports of this particular year there were ten pretty obvious cases of cerebral hæmorrhage, and two others in which the diagnosis was doubtful. Of the ten cases, nine died, and there were eight post-mortems. If we take the chief points as above—

1. The *onset* generally was not known.

2. The *patient.*—The ages average to 48, the youngest being 22. They were all males. One woman is affected to three men at most, but women are taken ill at home—and probably stay there.

3. The *pulse* was usually 90, with a thick-walled artery and of high tension. In two cases it was rapid.

4. The *temperature*, as a rule, was above normal, *i.e.*, reaction was occurring, and also it must be remembered that the temperature rises soon in severe and fatal cases. In three cases there was what we may call a hemiplegic temperature, but in others the wrong side was the hotter. In the case of pontine hæmorrhage the temperature was 99.2°.

5. Evidence of *hemiplegia* was present in over half the cases, and was by far the most valuable symptom. In two cases there was rigidity also on the opposite side; in one of these blood was effused into the pia, in the other blood was in both ventricles.

6. *Reflexes.*—Knee-jerks were an uncertain factor, but were increased in half the cases. *Plantar reflex* was usually extensor, especially on the paralysed side. *Ankle clonus* was present in half the cases, generally also only on the paralysed side. Other reflexes were not recorded.

7. The *respirations* were classically stertorous, irregular, or of Cheyne-Stokes rhythm.

8. The *eyes.*—Pupils generally were equal and contracted, but varied greatly. They were "pin points" in the pontine case. *Conjugate deviation* was present in four out of the ten, in three towards the lesion, in the other, a typical, capsular, paralytic case, away from the lesion.

9. *Incontinence* was noted three times. The *urine* had albumen in half the cases, in one case also albuminuric retinitis coexisted. *Glycosuria* was present in two cases. In one case cirrhosis of the liver was found. In this case the hæmorrhage was into the meninges, with small independent pontine hæmorrhages.

CEREBRAL EMBOLISM.—The symptoms are very like hæmorrhage. The patient is probably younger, and has a source for the embolus; most often a vegitative mitral or aortic valve, or a clot in an auricular appendix. Most emboli get into the left carotid, and so cause aphasia and right hemiplegia. The paralysis is more likely to be defined, the brain substance not being ploughed up as in hæmorrhage, but a definite area only being rendered anæmic.

During the year there were three cases diagnosed as embolism, but one was very doubtful, so we will not now consider it. *One patient* was a man of sixty with a thoracic aneurysm, who was found unconscious in his bed in the hospital. He had rigidity and increased reflexes on the left side, facial paralysis on the right side, conjugate deviation to the right, an insensitive cornea and Cheyne-Stokes respiration. No one will quarrel with the diagnosis, I think, though an autopsy is not recorded.

The other case was that of a boy of 14, with evident ulcerative endocarditis. He was taken with sudden coma, there was some vomiting, the cheeks were flushed, the respirations were regular, the knee-jerks were increased. He recovered from that attack but a few days later became again suddenly unconscious and died. In this case also there was no autopsy recorded, but the second attack was supposed to be due to hæmorrhage at the site of embolism, but it might, of course, have been due to another embolus.

THROMBOSIS may produce exactly similar symptoms, but is usually of more gradual onset. Atheroma strongly predisposes to it, so does much exertion in old people. It also may occur in puerperal, pregnant, or chlorotic women. There was no case in the year's reports.

CONCUSSION.—This is exceedingly common, and the symptoms vary widely, of course, with the severity of the injury.

With the slight attacks we have nothing to do in this paper; therefore we will briefly consider the symptoms resulting from an injury sufficient to cause definite unconsciousness.

1. Often no injury will be evident.

2. Depth of coma. In most cases the patient can be roused if sufficiently strong stimuli are used—the paralysis is only functional.

3. The *pulse* is probably always slow and weak in the condition of shock immediately after the injury. When the case is seen it is just as likely as not to be faster than normal. It is nearly always fast during reaction.

4. The *temperature* is consistently subnormal.

5. The *respiration* is usually slow, shallow, and may be sighing.

6. The *reflexes* are usually present, both superficial and deep. In severe cases they may be absent.

7. The *eyes*.—The pupils most often are dilated and equal. Light accommodation is sluggish, or in very grave cases absent. The corneal reflex is similarly present or absent.

8. The *sphincters* are usually relaxed, but the organs themselves are not paralysed, and, in consequence, there are involuntary evacuations.

9. The *skin* is cold and the face pale.

When *reaction* occurs the temperature rises, as does the pulse rate; and vomiting often occurs early. The patient may turn on to his side, or complain of headache. A continuation or recrudescence of the coma may mean meningeal hæmorrhage, depressed bone, spreading œdema causing compression, laceration of the brain, or encephalitis.

In the year's reports I have followed the rule of including those cases in which the patient was "unconscious but could be roused," whilst excluding those in which he was said to be "drowsy" or "dazed." Dividing the cases thus, there are twenty-two cases of concussion uncomplicated by laceration of the brain or by compression, or at least apparently uncomplicated.

1. *As regards injury*.—In fifteen out of the twenty-two there was an obvious lesion or some evidence of it; either wound, bruise, or hæmorrhage from nose, etc.

2. *Depth of coma*.—In eight out of the twenty-two the patient could not be roused.

3. *Pulse*.—Excluding the children, in whom the pulse rate would be faster, the average rate is 73·6 to the minute. Taking the normal as 72, seven cases had a slower pulse than this, and only four a faster. The slowest was 42, but there were two of 48. In only one case was it above 100 in an adult.

4. The *temperature* was subnormal in most cases.

5. The *respirations* were usually called "shallow."

6. The *reflexes* have not been recorded.

7. The *eyes*.—The pupils mostly were dilated, rarely contracted, and in two cases unequal. In one case conjugate deviation was seen, but as twitchings and rapid pulse coexisted, laceration was probable.

8. The condition of the *sphincters* has been neglected in the reports.

COMPRESSION.—That due to depressed bone will be here neglected. One case occurred, which is alluded to below.

Subcranial hæmorrhage—usually middle meningeal. This is rare, but is given prominence in the text books because of its importance. Mr. Jacobson in 1886 had collected 70 cases only in the last century, and though it must be more frequent than those figures would lead us to expect, still the average student at a hospital may count himself lucky if he comes across a case. In 1902 there were three cases.

I am indebted to Mr. Jacobson for the following notes which are taken from a paper written by him in the Reports for 1880. In most cases coming to autopsy, cerebral laceration or bruising was found also.

External signs of injury.—Of the 70 cases, in only one was it impossible to find a bruise on shaving the scalp. In two no signs were found before shaving; in five no injury was noticed. Therefore, in one out of seven cases we may expect no injury upon cursory examination, but in probably only one out of thirty-five or so, will there be no injury found when shaved. In one case out of fourteen the hæmorrhage was on the side opposite to the injury.

Symptoms in order of importance.

1. A *lucid interval* after the concussed stage is well marked in half the cases, little marked in one-sixth and absent in one-third. The interval may be absent owing to the severity of the injury prolonging the concussion, or to the drunkenness of the patient. Mr. Jacobson laid great stress on this sign. The lucid interval may rarely last as long as eleven days.

2. *Condition of limbs* as regards paralysis. Seven conditions may be met with—

(*a*) Hemiplegia well marked in one-fourth of the cases.
(*b*) Hemiplegia little marked.
(*c*) Hemiplegia present, but temporary.
(*d*) Hemiplegia more marked in one limb.
(*e*) Paraplegia.
(*f*) Absence of any paralysis.
(*g*) Limbs rigid or twitching.

3. *State of pupils*. The Hutchinson pupil, *i.e.*, the pupil on the compressed side dilated and fixed, is of first importance. The dilatation may be preceded by contraction, and a similar cycle may follow in the other pupil. The pupillary reactions are also valuable for prognosis.

4. The *pulse* is slow, full, and heaving, and perhaps rapid before death.

5. The *depth of coma* depends upon the rate as well as the size of the hæmorrhage.

6. The *respiration* is stertorous, moaning, irregular, or of Cheyne-Stokes' rhythm.

7. The *scalp* generally shows injury as above.

8. The *sphincters* are paralysed, and also the bladder itself.

9. The *temperature* is subnormal, and rises with the pressure; that of the first paralysed side may be the higher.

10. Vomiting, hemianæsthesia, aphasia, or automatic movements may be seen.

Of the three cases in 1902, all had signs of trauma. None had any paralysis, one had bilateral rigidity. Two had a definite lucid interval. Two had the Hutchinson pupil, in one case preceded by dilatation of the opposite pupil, possibly due to laceration of the vein on the opposite side. Two had normal pulse rate, in the other case it was 94.

Depth of coma.—Two needed no anæsthetic for trephining. The respirations were stertorous in one case, jerky in another, and fast in the third. One in nine of Mr. Jacobson's series recovered. Nowadays better figures should be obtained.

CONTUSION AND LACERATION OF BRAIN.—The symptoms are said to be a mixture of those of concussion and compression, and also irritative effects are laid stress on, such as spasms of groups of muscles. These latter effects are often not seen, and it may be quite impossible to diagnose laceration from compression. There were seven cases in the year, and in five of these the diagnosis was confirmed by post-mortem examination. In most cases there were irritative symptoms.

(NOTE.—I find that there was one more case of compression than is recorded above. The hæmorrhage was subdural. The patient had other severe injuries and died one hour after the operation).

EPILEPTIC COMA.—The most important point is to get a correct history. The fit consists of:—

(*a*) The aura (in half the cases).
(*b*) The cry sometimes.
(*c*) The tonic stage.
(*d*) The clonic stage.
(*e*) The comatose stage, in which we are chiefly interested.

The most characteristic feature of this coma is the rapidity with which it disappears. For the first few minutes after the cessation of the convulsions it is profound. There are total relaxation, absent reflexes, and perhaps stertorous breathing, quite like apoplexy. Very slowly the patient gets simply sleepy, and can easily be roused. The deep reflexes are then increased. The urine may contain albumen or a reducing body. Rarely hemiplegic signs persist for a short time. Headache and confusion usually succeed and the mental state of the patient is somewhat characteristic. A history of previous fits may be got from him pretty early. Other points in diagnosis:—

1. A bitten tongue.
2. Probably the youth of patient. His face may be pale, congested, puffy, or even œdematous.
3. Petechiæ may be found.
4. Bruises may be found.
5. Urine or fæces may be present in the clothes.
6. There is sometimes a marked tendency for the patient to turn on to his face, and if in bed he may be suffocated.
7. The pupils vary from time to time usually.

Two cases are entered as post-epileptic in the year. One had some loss of tone of right arm, but his breathing was not stertorous, his pulse was 120 and his temperature 100. A history of fits was obtained.

In the other case there were slight tremor of the arms, rigidity of the legs, and a reducing body in the urine. In this case Dr. Hale White diagnosed syphilitic endarteritis.

Other epileptiform attacks are caused by:—

1. *Cerebral syphilis.* — Suspect this when the first attacks occur in a middle aged man. It is characterised by a random association of symptoms, with possibly relapses and oculomotor paralysis. Rarely a gumma may cause sudden coma. One case of this kind occurred.

2. *General paralysis* of the insane is characterised by two kinds of attacks.

(*a*) The epileptic. There may be one-sided convulsions, or paralysis, or twitchings.
(*b*) The rarer apoplectic, with stertorus breathing, relaxed limbs, and flushed face.

An attack such as the above may be the first symptom of the disease. There was only one case in the year.

3. *Disseminated sclerosis* may give rise to similar attacks with coma.

ALCOHOLIC COMA is so exceeding common in what we may call its minor forms, *i.e.*, cases of incomplete coma, that in attempting to diagnose these cases we usually simply seek for symptoms which preclude the possibility of the case being one of drunkenness. Yet cases of really deep alcoholic coma are much rarer; I have only seen one, alluded to below, and in the year's reports there are only two cases of alcoholic coma, that is, only two were comatose enough to be taken in after the usual wait in the Front Surgery.

The *mental state* of the patient in the minor cases is too well known to need description.

The *pupils* are usually dilated, or may vary. If contracted, they will usually dilate on stimulation and recontract.

The *respiration* is very rarely stertorous, though deep.

The *temperature* is mostly subnormal. According to Rolleston in cases in which there are convulsions, the temperature may continue to rise until death.

Twitchings may occur, more rarely convulsions.

The *face* is flushed or pale.

The *pulse* is said to be bounding, but certainly sometimes a weak and rapid pulse is seen.

The *urine* is probably of low sp. gr. Only when very large doses have been taken can alcohol be detected in the urine by the iodoform and aldehyde tests.

The *odour of the breath* is usually of no diagnostic value.

In one case the patient was found comatose in a public house. He was washed out in the Front Surgery, and yet

after five hours he had no evidence of returning consciousness except a slight conjunctival reflex, which before had been absent. On admission he had no reflexes and the battery was of no effect. The pupils were contracted, and the bladder was full. The next day he had quite recovered.

The other case was that of a man aged 60. No history of fits was obtainable, though he was known to be a drinker. On admission he had general convulsions and coma. The temperature was normal. Respirations 28, and pulse 124. The urine was passed involuntarily. Albumen was in the urine. The next day he also was quite well.

Uræmic coma may come on suddenly. Usually there is a history of previous Bright's disease, or of recent headache, vomiting, dyspnœa, or convulsions. The most characteristic feature is the convulsions, and the most characteristic feature of the convulsions is the fact that they are repeated, alternating with coma.

The fits may be typically epileptic, or they may resemble Jacksonian epilepsy, or there may be only twitchings. Twitchings and convulsions may both be quite absent.

The *urine* will have probably much albumen and epithelial casts.

The *pulse* is slow and feeble.

The *respirations* are often of Cheyne-Stokes' rhythm.

The *temperature* is generally subnormal.

Two cases are recorded.

One man after three days' increasing drowsiness became suddenly comatose. There was continuous twitching of one side of the body, with rigidity of the opposite side. The pupils were contracted. Later the movements were all on one side, but the other side was not paralysed, Lumbar puncture was practised between the third and fourth lumbar spines, one inch to the right of the middle line. Half an ounce of cerebro-spinal fluid was collected in thirty-five minutes, and during this time the movements ceased and the patient got distinctly better. I think this is the first case of lumbar puncture for uræmia in this country.

There are no particulars of the other case of coma.

Diabetic coma.—As to its onset, Pavy says, "It cannot be said that it comes on rapidly in the form of a fit." Osler gives three modes of onset—

1. The usual gradual, with vomiting, headache and "air hunger."
2. Sudden, after exertion.
3. Sudden, not after exertion. This is more rare.

A case was admitted a year or two ago which had suddenly become comatose while at a concert. Excitement may precede the coma and make the case look like one of alcoholism or hysteria. The patient is *young*, thin, with a dry skin probably. He can be roused. He may have the typical *air hunger* (described by Osler as dyspnœa affecting both inspiration and expiration). The respiration may get very slow. In a case in John the rate several times fell to eight per minute.

The *urine* has sugar, diacetic acid and acetone.

The *breath* has a characteristic smell.

The *temperature* is subnormal. Elliott records a case in which it was 90° twenty-four hours before death.

The *pulse* is quick and soft.

The *tongue* may be "beefy."

Two cases occurred in the series—

One had all the typical signs mentioned above. Her breath was stated to scent the corner of the ward in which she lay.

The other was in a man of 31, and was also characteristic.

The first patient was brought out of coma once by the alkaline treatment, but this did not succeed on a second application—the usual result.

Opium poisoning.

The *pupils* are usually minutely contracted except just before death.

The *breathing* is shallow, slow, laboured, irregular, and perhaps stertorous.

The *pulse* is slow and compressible.

The *skin* is cold and moist, and the features shrunken, pallid, and cyanotic.

The patient dies of respiratory failure with deepened cyanosis. Vomiting or twitching may occur. The temperature is subnormal. The opium may be smelt.

There were two cases—

In one the patient was cyanosed, with warm, dry skin, and could not be roused. Stertorous breathing, a full pulse and small pupils were present. There was no smell. The temperature was not recorded. It would have helped in the diagnosis, as we should expect it to be raised in a hæmorrhage with small pupils.

In the other case there was a history of fits and alcoholism, but none of poison. The face was ashy, the lips blue, the skin dry and cold. The respirations were at the rate of nine to the minute and irregular; the pulse also was slow and irregular; the pupils were contracted. This case was not diagnosed, but morphine was found in the gastric contents.

There was also a case of hyoscine poisoning which got completely comatose.

Rarer causes of coma.

Heat exhaustion is characterised by a cool surface, a small and rapid pulse, and a low temperature; but the senses are often entire.

Sunstroke (usually seen in alcoholic soldiers after marching in the sun) causes headache, giddiness, oppression, nausea and vomiting.

The temperature may go up to 110°, the face being flushed and skin pungent.

The respirations are laboured, slow, and perhaps stertorous.

The pulse is rapid and full.

The pupils are contracted.

General relaxation is usual; rarely there are twitchings and convulsions.

The asphyxial form is yet more severe.

Coma may follow prolonged *exertion* without exposure to heat.

Cholæmia may cause a rapid coma in jaundiced patients.

Simple syncope is a very common form of simple loss of consciousness, of course most often seen in anæmic and hysterical young women.

The fatal syncopal attacks of *cardiac disease*, especially of aortic disease, should be considered.

Tubercular, and simple, basal meningitis cause perhaps most deaths in comatose persons. The patients are nearly always young children and a history can be obtained.

Suppurative meningitis causes a yet more rapid advent of coma. Look for a source of infection.

In hot climates the comatose form of *malaria* should be considered.

Other causes of coma or feigned coma are acute encephalitis, catalepsy, conditions of trance, carbolic acid and other poisons, cerebral abscess or tumour, spreading œdema after cranial injuries, malingering.

(*To be continued*).

Reviews.

The price of books submitted for review should in every case be stated.

On the Origin from Accessory Fallopian Tubes of Cysts of the Broad Ligament situated above the Fallopian Tube. By W. Sampson Handley, 16 pp.

This, a reprint from the "Journal of Obstetrics and Gynæcology," is a short paper proving that many broad ligament cysts, at present considered as arising from the parovarim, actually arise from distension of accessory tubes. Mr. Handley, by a careful observation of some specimens in the Royal College of Surgeons Museum, brings conclusive evidence in favour of his theory of origin.

The pamphlet is interesting and will well repay perusal.

A Case of Intra-ocular Lipæmia, in which Blood was examined during life. By W. Hale White.

A small interesting paper, reprinted from the *Lancet* of Oct. 10th, 1903, in which the clinical history and an account of the result of chemical examination of the blood are given. Prefixed is a good coloured illustration of the patient's disc.

The Infectivity of Malignant Growths. By G. Bellingham Smith and the late J. W. Washbourn. (Young J. Pentland). 14 pp.

A pamphlet, reprinted from *Edinburgh Medical Journal*, containing a short review of the theories of origin of malignant growths, and setting forth the evidence in favour of infectivity. The paper is concise and portrays succinctly the bent of the medical mind of the present day with regard to malignant affections.

Sport.

CRICKET FIXTURES.

Saturday, May 21st.

G.H.C.C., I., v. Wanderers, home, 11 a.m.
" II., v. Old Olavians, away, 2 p.m.
" III., v. Camberwell House, away, 2 p.m.

Monday, May 23rd.

" I., v. Norbury, away, 11 a.m.

Wednesday, May 25th.

" I., v. Surrey Club and Ground, home, 11 a.m.

Saturday, May 28th.

" I., v. Reigate Priory, away, 11 a.m.
" III., v. Hos.-Scho., home, 2 p.m.

Wednesday, June 1st.

" I., v. Brixton Wanderers, home, 11 a.m.
" III., v. Brentwood Grammar School, away, 2 p.m.

Saturday, June 4th.

" I., v. Old Eastbournians, home, 11 a.m.
" II., v. Beddington, away, 2 p.m.,
" III., v. Camberwell House, away, 2 p.m.

Cricket.

The usual trial match took place at Honor Oak Park, on Wednesday, May 4th, between the Freshmen and the 2nd XI. There is little to be said about the match as there were no performances of any great merit. H. Simms and H. Archer showed useful form with the bat, but there was a lack of bowlers. This is most unfortunate as bowling will probably be our weakness this season; a good slow bowler is greatly needed. S. A. Piper and G. E. Rice bowled well for the 2nd XI.

GUY'S v. LONDON COUNTY.

Played at Honor Oak Park, on Wednesday, May 11th.

W. G. Grace brought a fairly strong side against us, and, winning the toss, took first innings on a slow wicket. Our bowling was very loose at the start, and 50 soon appeared on the board; a change was then tried and Hay was dismissed for 41. W. G. Grace left soon after, caught by the wicket-keeper from a skyer. Three wickets quickly fell after this, when Poidevin and Gamble came together and stayed till the luncheon interval, when the score was 130 for five wickets.

The wicket appeared to have become more difficult on resuming. Gamble was soon out, and with the others doing little, the innings closed for 188.

H. Barber and J. S. Bookless opened our innings, but with only 13 scored Bookless was caught at the wicket. The second wicket fell at 38, of which Barber had made 30; he was soon after caught at the wicket for 39 out of 49 made in his best style.

Husbands and Simms made a short stand, the former making some good hits, but the last five wickets only added 14 runs, and the innings closed for 85.

W. G. Grace decided to bat a second time, but the visitors fared very badly against the bowling of Davies and Piper, 7 wickets falling for 25 runs, when Poiderin and Murch came to the rescue, adding 45 without being parted.

GUY'S v. R.I.E.C.

Played at Cooper's Hill on Saturday, May 14th. The home side won the toss and took first innings, the first wicket fell before a run had been scored, but our bowlers did not meet with much success afterwards. Most of the side got into double figures, the total being 203. Wyatt was the most successful bowler, and had hard luck in not getting more wickets. We started with Bookless and Wyatt, but off the second ball in attempting a third run, Bookless was run out. Wyatt and Willan put on 51 for the second wicket, when Wyatt was out to a catch in the long field. Husbands was bowled at the same total, and 6 runs later two more wickets fell. Simms and Archer improved matters a little, but the seventh wicket fell at 74. Davies then joined Archer and began to hit in excellent style, Archer left at 96. Gibson was easily stumped at 114, and Piper, the last man, was caught at the wicket five minutes before time, leaving us defeated by 67 runs, Davies carrying out his bat for 38.

GUY'S 2ND XI. v. BEDDINGTON.

This match was played at Honor Oak on May 7th, ending in a draw. Rice bowled well taking 5 wickets for 37 runs. Greening had the misfortune to break his little finger.

[Accounts of several matches have to be unavoidably held over until our next issue.]

Appointments.

Civil.

HINDS, H. A., L.R.C.P. Lond., M.R.C.S., has been appointed District Medical Officer of the Bridge Union.

Naval and Military.

Staff-Surgeon C. M. BEADNELL, R.N., is promoted to the rank of Fleet-Surgeon in His Majesty's Fleet.

Surgeon J. C. G. REED, R.N., is promoted to be Staff-Surgeon in His Majesty's Fleet.

Staff-Surgeon A. E. KELSEY, R.N., has been appointed to the *Andromache*.

Surgeon-Lieutenant W. L. CHUBB, M.D., 1st Cinque Ports, resigns his Commission; he is granted the honorary rank of Surgeon-Captain, and retains his uniform.

From the Gazette's Special Pathologist.

NOTICES.

G. M. J., ALTON.—This sputum contained a little pus, but tubercle bacilli were not found in it.

PATHOLOGIST.

Change of Address.

J. F. Goodman, L.D.S., from Guy's Hospital to 44, Southernhay West, Exeter.

W. S. Stevens, L.D.S., from Rotherham to 8, Weston Road, Stroud.

Dr. G. H. H. Manfield, from Basford, Stoke-on-Trent, to Shenstone, Lichfield, Staffs.

W. H. Yeo, L.D.S., from Guy's Hospital to 8, Rosebery Road, Exeter.

The Editor will be very glad to receive a postcard with notes of any change of address.)

Papers by Guy's Men.

Note on the Causation of Cancer. By H. J. Campbell, M.D., F.R.C.P.—*British Medical Journal*, April 30th.

Asylum Dysentery in Relation to Dysenteriæ. By J. W. H. Eyre, M.D., F.R.S. Edin.—*Ibid.*

The Use of Radium in a Case of Rodent Ulcer. By J. A. B. Hammond, M.B. Lond.—*Ibid*, April 23rd.

A New Form of Removable Deep Sutures for the Prevention of Stitch Sinuses. By Lawrie H. McGavin, F.R.C.S. Eng.—*Lancet*, April 30th.

Preventive Measures against Malaria in Kandia, Crete. By Major J. V. Salvage, M.D., M.S., R.A.M.C.—*Journal of the Royal Army Medical Corps* for May.

Note on a Case of so-called "Spontaneous Fracture" of the Femur from Secondary Malignant Disease with subsequent Firm Bony Union. By T. Morrell Thomas, M.D., M.S. Lond., F.R.C.S., and B. G. Fiddian, M.B., B.S. Lond.—*Lancet*, April 30th.

Case of Congenital Hypertrophic Stenosis of the Pylorus. By A. J. Cleveland, M.D., M.R.C.P.—*British Medical Journal*, May 7th.

Amaas, or Kaffir Milk-pox.—By W. E. de Korté, M.B. Lond. (Illustrated).—*The Lancet*, May 7th.

A Case of Septic Pneumonia; Abscess of the Lung; Aspiration; Recovery. By Arthur J. Sharp, M.D. Lond., F.R.C.S. Eng., and Hugh N. Keeling, L.R.C.P. Lond., M.R.C.S.—*Ibid.*

Births.

BALDERSTON.—On May 7th, at 30, Park Road, Forest Hill, S.E., the wife of Robert Balderston, M.B. Lond., of a daughter.

RAYSON.—On May 13th, at 86, Osmaston Road, Derby, the wife of H. Knight Rayson, M.D., L.R.C.P., M.R.C.S., of a daughter.

Marriage.

DENSHAM—SOPER.—On April 30th, at All Saints' Church, Devonshire Road, S.W., by the Rev. Canon Allen Edwards, Vicar of the parish and Rural Dean of Kennington, assisted by the Rev. L. W. Kitchlee, Vicar of St. Marks, St. Helens, Lancs., Alec Densham, M.B. Lond., of Woodville, Worthing, son of Benjamin Densham, of Bramley Croft, Hindhead, to Alice Marian, daughter of William Soper, M.R.C.S., L.S.A., of 307, Clapham Road, S.W.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 420.] JUNE 4, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	221–223
Nine Cases of Ovariotomy for Torsion of the Pedicle. Clinical lecture by Mr. C. J. Symonds	223–227
A Question of Diagnosis	228–229
Princess Christian and the Ladies' Association	229–230
Guy's Hospital Clubs' Union	230–231
The Wills Library	231
In Lighter Vein	232
Reviews	233–234
Guy's Hospital Debating Society Dinner	234–235
The Diagnosis and Treatment of Coma ...	235–240
From the Gazette's Special Pathologist...	244

Passim.

TO discuss the weather is rightly considered to be the refuge of those destitute of ideas, and it is possible that there may be some in this present instance who will lay this shortcoming to our charge. But surely it is fair to say that something nobler than a mere desire for small-talk prompts us to bemoan the manner in which June has made her *début*. That May should have been an intensely dissatisfying month was culpable enough on the part of those who have from time immemorial been held responsible for the weather; but that the first day of the "joyous month," and Derby day into the bargain, should have been allowed to have been the miserable parody of summer weather that it was, shows a brutal disregard for humanity that calls for the censure of the most stoical. Should July or August, or any ensuing month prove fine, even beyond our wildest dreams, it will be with but a chastened gladness that we shall receive such overtures of peace on the part of the weather people.

THE Debating Society's Annual Dinner, an account of which appears in another column, was a most enjoyable entertainment. The date chosen was apparently an unfortunate one, for many of the Society's most regular supporters were conspicuous by their absence, in fact the number of those present was considerably less than last year; but the success of the evening was never for a moment in doubt on that score, for the President, Dr. Savage, was in the chair, and never have we heard him speak to better advantage. His infinite variety of anecdote, and the delightful way in which he narrates the same, will ever be a wonder to those who hear him, and though on this occasion he confined himself to the experiences of a comparatively short period of his career, the general impression was, on his resuming his seat, that the tale was not even half told. There was, too, a peculiar charm in these anecdotes. We enjoyed Dr. Savage's Reminiscences of Guy's on the occasion of the Society's last annual dinner, but then his talk was very largely of other people, many of whom were but names to junior men, whilst on Tuesday last his recollections were more personal and therefore of an especial interest. As an overworked practitioner in an extensive mining district in Cumberland he got at the heart of things, where many a lesser man would have heeded only the drudgery, and we dare swear that the miners have never had a more sympathetic doctor either before or since.

Without any undue insistance upon the moral of his tale, Dr. Savage made it abundantly clear that the most valuable experience is that gained for one's self and by one's self. To be completely cut off, as he was, for all practical purposes, from the expert assistance upon which the practitioner can usually rely in his treatment of a difficult case, is the finest schooling possible, whatever the ultimate post may be that a man is called upon to fill. But we are inclined to believe that something over and above mother wit and sound training is necessary in coping with such difficulties as Dr. Savage had to face, and that while he made a necessity of virtue, many of us would, from temperamental defects, reverse the process, and that where he got primary union after operating with a scalpel and a butcher's saw, we should consider ourselves extremely fortunate if we did not have a death from shock!

Elsewhere we publish a full account of the Ninth Annual Meeting of the Ladies' Association, the first to be graced by the presence of H.R.H. the Princess Christian, since her acceptance of the post of President last year. The meeting appears to have been successful in every way, and it must have been satisfactory for those who have carried on the useful work for so many years to have been able to point out to the Princess the help that her patronage has already given to the Association. To those of us who work in the wards, the almost unlimited scope for the Association's efforts is obvious. We heartily commend to our readers' attention the appeal of Mrs. Benyon, the chairman of the committee, for increased membership, and would suggest to past and present students, that they should bring the Association to the notice of their relatives.

All will heartily congratulate Mr. H. Watts on his winning the Montifiore Medal and £20 prize in Military Surgery at Netley.

We have received a letter from our correspondent on board the R.M.S. *Ormuz*, and those interested in the fortunes of the Guy's contingent with the Anglo-Australian Football Team will be pleased to know that they are all well and flourishing. On joining their ship at Marseilles they were pleased to find that the ship's doctor was a comparatively recently qualified Guy's man, Mr. J. F. Robinson to wit, so that this Hospital is well represented on board. Seasickness was never so much as named amongst them, but indisposition the noble five confess to, and here we will refrain from repeating the harrowing details our correspondent sends us as to the extent of this indisposition in the cases of the more senior of the five. Paris, Naples, Pompeii, each in their turn, and in their own way, have entertained the travellers, even Vesuvius consenting to glow for their benefit, a condescension which was much appreciated. The ship's doctor's active treatment of a man, who fell overboard and was picked up after an exciting twenty minutes, forms the subject of an interesting paragraph, while the account of a concert in which the talent was principally Guy's talent makes one feel like Christmas again, though we are not actually told whether there was a sword dance on this great occasion. We anticipate more news from this source in the near future.

As regards Cricket, the gloomy forecast which we made in a previous number has not been confirmed by the events. A most commendable spirit of keenness is characterising the doings of the 1st XI. at least, and we have no doubt but that the same spirit will make itself felt in the other elevens. On Friday last our First managed to win the first round of the Hospital Cup Tie against Westminster, and it is to be hoped that Charing Cross, who are to be encountered next week, will meet with a similar fate at our hands. Of course the prospect of actually winning the Cup is a small one, but it is an excellent sign of the times that our men are willing to make a sporting effort against heavy odds.

The Annual Athletic Meeting will be held at Honor Oak on Wednesday, June 22nd, and no doubt with good weather will prove as pleasant a function as it ever has done. We could wish,

however, that there was the remotest possibility of a word in season inducing all the athletic men to take the trouble to train for the various events. Were it not for the crowds of beautiful ladies who annually attend, for the strawberries and cream procurable at moderate prices, and for the donkey race, pregnant with possibilities, this insultingly untrained condition of most of the competitors would strike one more forcibly than it does. The fact that the three-mile race last year consisted of two men running round the band in generous circles, could not mean that there were only two men capable of making a respectable show in a three-mile race. In view of this general absence of preparation, the ostentatious business of entering for all events would be ludicrous, were it not for the financial cunning displayed, and which it is impossible not to admire.

WE wish to call special attention to an article in another column on the Wills Library, with an account of a scheme at present on foot for furnishing the same with the most acceptable books and periodicals.

Nine Cases of Ovariotomy for Torsion of the Pedicle.

CLINICAL LECTURE BY MR. C. J. SYMONDS.

March 23rd, 1904.

GENTLEMEN,—I propose to-day to call your attention to a patient who has just left Lydia ward, an interesting case of torsion of the pedicle of an ovarian tumour. Here is the specimen removed from this woman, and it shows several interesting points illustrating this particular complication in connection with ovarian tumours. Her history is somewhat indistinct, and I think it is also a little misleading. She was a woman, æt. 21, who was married and had had one child seven months ago. She was again three months advanced in pregnancy when she came in. She says that on getting up from her confinement she had some pain in the abdomen, evidently she was not quite comfortable. She thinks it was the same kind of pain as she had in her recent attack, but that was thought over afterwards and seemed to be not very reliable information. Her history begins a week before admission, when during the night she had an attack of pain lasting till morning. Next day—Monday—she was sick. She does not appear to have been sick very often, nor was it a very distressing symptom. The pain in the abdomen lasted a week, at the end of which time she was admitted into hospital. In the early days of this attack she noticed a lump in the abdomen, and the medical man who attended her noticed it too. She is not aware of ever noticing a tumour in the abdomen before this. The history therefore was quite a short one, a pregnancy and a normal delivery at term, a fresh pregnancy of three months' standing and a sudden attack of pain followed by vomiting, the pain continuing during the whole week before admission. When she came in there was a large tumour to be felt in the left anterior lumbar region, it could also be seen as she lay in bed. It was exceedingly tender, so that manipulation was difficult. It projected back into the loin and could be held between the two hands and could be pressed back into the loin quite easily, in fact, when we turned her over on her side the loin remained prominent. That was a special feature leading to the error in diagnosis. Owing to the tenderness it was impossible to manipulate the tumour with sufficient freedom to differentiate between some renal tumour or one of some other kind, of which the most likely was an ovarian. The situation you will see rather suggested that it was renal, from the history of sudden formation, that it was a collection of urine, a hydronephrosis, due either to the blocking of the ureter by a stone or to some congenital condition leading to obstruction of the ureter. But even then it is almost impossible to imagine that so large a hydronephrosis can occur in such a short time; they are slow-growing formations, caused by intermittent obstruction. Sudden closure of the ureter does not necessarily lead to enlargement at all. Ligature of the ureter, passing from a normal kidney does not lead to hydronephrosis, but to atrophy. So mere obstruction does not produce hydronephrosis. Therefore it seemed difficult to explain how this large tumour had arisen if it was due to a collection of fluid in the dilated pelvis of the kidney. However, it might very well be that this patient had not noticed a tumour before, but that one had been present a considerable time, a slight increase in size having determined its recognition. Another point against it being kidney was that the colon could not be traced down the front of the swelling, either by palpation or percussion. Another point very much

against it was the absence of a history of the escape of a large quantity of limpid urine, such as we know to be characteristic of hydronephrosis. A fluctuating renal tumour seemed, however, the most likely explanation. Ovarian was suggested, as I have said, but I am afraid it was not worked out as carefully as it might have been. Pelvic examination revealed the pregnant uterus, but there appeared to be no attachment between the tumour in the loin and the pelvic organs, a point that rather put us off the ovarian origin.

At the operation it became a question of what was the best method of removing the tumour. The pain was very great, and it was necessary to do something. Ought we to operate from the front, or from the loin? Looking upon it as renal, and as of sudden formation, and the absence of a temperature, of pus or blood in the urine, clearly it was best to attack it from the loin; and one turned the patient over and exposed the tumour in the loin. On doing so, and putting a pillow under the abdomen, the tumour projected into the loin, and was easily seen. On going through the muscles and reaching the situation of the peri-renal fat, none of this fat appeared, but instead, a loose fold of peritoneum could be seen, and through it the bluish outline of this tumour. That did not look like kidney, and therefore one separated the tissues a little higher up, and found a normal kidney in the usual situation.

It was obvious that the tumour was free in the abdominal cavity, and that it was an ovarian. The patient was turned over on her back, and one said if this is an ovarian tumour it ought to be possible to raise it out of the loin and move it anywhere in the abdominal cavity. So before opening the abdomen I pressed the tumour from the loin, and could transfer it freely to the opposite side. That ought to have been possible clinically in the ward, and if so, it would have settled the diagnosis at once. But it was too tender to permit of this. I daresay it was a little fixed by inflammatory material; some light adhesions are still visible on the surface of the tumour. The abdomen was opened in the middle line and the tumour removed. On opening the peritoneum it was seen to be greatly injected, and covered with recent vascular lymph; this was all over the left side and middle of the abdominal wall, indicating that that there was some inflammatory action going on. The tumour was of a deep purple colour from the presence of blood within the sac. However, it was turned out quite easily, and then one was able to demonstrate that the cause of the congestion and blueness was the twist of the pedicle, which you can see. I have had the pedicle re-twisted and sewn in the position in which we found it. It is a very good example of torsion of the pedicle.

On dividing the pedicle the veins were found full of clot, and stood out as large as cedar pencils. That will show how a twist of the pedicle will lead to hæmorrhage into the cyst wall, and inflammatory action over it. The uterus was found to be in about the fourth month of gestation, very soft, and practically normal. The abdomen was closed with three rows of sutures, and the patient put to bed. She got well without any trouble, and at the end of the third week she went home well. You will observe that no trouble resulted with the pregnancy, and I have no doubt she will go to term in the usual way. That is the common thing in such cases nowadays. Even fibroids have been enucleated without interfering with the pregnancy.

The first point I want to take up is, What was the cause of the error in diagnosis in this case? I think it was because it was so tender that it was impossible to test its mobility. It is not an uncommon thing for an ovarian tumour to occupy this position, and one must know that that is one of the causes of a swelling in this situation. The mobility settles the question. If you can make the tumour move across the abdomen it is probably ovarian.

You may ask me why I selected this loin operation. I did it because I thought it better in a case of this kind, with pregnancy, to drain the hydonephrosis only, and not remove the kidney. Perhaps I might have to remove a stone from the ureter and so save the kidney altogether. Or one might have thought it wise to suture the ureter to the pelvis of the kidney, and make a new junction between the ureter and pelvis, as in some of these congenital malformations, rather than remove the kidney. The loin operation was selected because it might turn out to be hydronephrosis.

Next, how is the sudden appearance of this tumour to be explained? No doubt it originally lay in the pelvis, and as long as the uterus was small it remained there; there was room for both. But when the uterus enlarged, the tumour rose out of the pelvis, and made its appearance in the abdominal cavity. It is important to remember that, because it explains the apparently sudden appearance of many tumours. This tumour came out of the pelvis at about the period one would expect; *i.e.* when the uterus had reached its fourth month of enlargement.

Another interesting point about this case was that the tumour had greatly increased in size during the week the pedicle was twisted, owing to the exudation of blood. I think it probably doubled its size.

The situation of this tumour is unusual for ovarians with a twisted pedicle. It occupied the left lumbar and iliac regions, and reached high up, though not quite under the ribs. When tumours of the kidney enlarge they tend to come down. So that was not very much against the diagnosis of it being kidney. But when the pedicle of an ovarian tumour becomes twisted it obviously becomes shortened, and then the tendency of the tumour would be to come down towards the pelvis and become fixed there. To take a case in point, that of a lady about 65 or 70 years of age. I was called to see her by Dr. F. W. Cock, for an acute attack of abdominal pain and vomiting which he attributed to torsion of the pedicle of an ovarian tumour. When I arrived, the tumour occupied a position almost opposite to that in the case we have been discussing, viz., on the right side. The pain had disappeared, and so had the vomiting. It was possible to take this tumour and move it across the abdomen. It swung in a characteristic direction, downwards and towards the other side, and moreover dragged on the uterus. The torsion in this attack had been of short duration.

The question was, What was to be done? It was clear that she was liable to a second torsion at any time; but as she was away from home and from her usual medical care I thought it better that she should finish her holiday in London and return to the country, and place herself in the hands of her own medical attendant, letting him arrange for this tumour to be removed. That was the plan adopted. But a few days before she thought of leaving, she had another attack, and I was summoned to her then while she was in pain. The tumour was now occupying the left iliac and hypogastric regions, showing that the pedicle had become twisted and shortened, that the tumour had been drawn down into the pelvis, and there had become fixed. The temperature was up to 100° to 102°, and there was considerable tenderness and pain. I thought it better to wait a few days until the temperature went down, and the peritoneal irritation subsided. Perhaps it is an open question whether it is wise to wait in these cases. In a week the temperature was normal, and then on operating we found a tumour connected with the left broad ligament with the pedicle tightly twisted. The cyst was dark and obviously full of blood. The peritoneum in its vicinity was deeply injected, and there were many light adhesions.

In this case I put a rubber-gauze tampon drain into the pelvis, because there was a good deal of serum in the pelvis, and there had been a good deal of pyrexia. However, I think the drain was a mistake. It did not do her any harm, but I think it caused a little unnecessary distress. I do not think the presence of a drain is required in such conditions. With that exception the patient did very well. I think that is the typical behaviour of these tumours; they have a long pedicle, they occupy a high position in the abdomen, even up to the loin, and when twisted they gave rise to these sudden symptoms. When the twisting of the pedicle occurs and draws the tumour down into the pelvis, it becomes fixed and gives rise to local irritation. The case which I made the text of these remarks was unusual in these respects.

The question was whether, in the case of the old lady, I was wise in waiting for a week for the temperature to subside. I think that is open to criticism and that it is better to operate at once; there is no special danger in operating even with a temperature of 102°. Probably the temperature is due to the condition of the sac itself, and removing this tumour will remove the cause of the pyrexia and irritation, and is the best thing to do. We might possibly have saved this patient four or five days of illness.

There is another very interesting case, which I think is again a little different. The patient was rather a typical Jewess, æt. about 50, and was very stout. She had had several attacks of abdominal pain, which had not been very well explained. It was something like an appendicular attack, but differed from such in that the pain was quick and of short duration. There was no difficulty in discovering a tumour in the lower part of the abdomen, and by vaginal examination this could be found to be attached to the broad ligament. So we concluded she had a tumour of a very hard variety in which the pedicle occasionally became twisted and gave rise to disturbances, and it became a question of removal. She had extensive glycosuria, and in all such cases it becomes a question whether operation should be done or not. However, as her health was good and the sugar did not appear to be doing much harm, we thought the operation might be carried out. We found the tumour to be a typical dermoid, containing oil, hair and so on. The wound behaved well, and she recovered notwithstanding her glycosuria. On that point I might mention a man, who was in the ward

last year on whom I did gastro-enterostomy in a condition of rather serious glycosuria. He had a good deal of wasting, and subsequently had gangrene of part of his face, and other symptoms showing that the glycosuria had done him a great deal of harm. But he went through his operation with no special feature worthy of note; some three years later he died of glycosuria. There are other cases one might mention, showing that the presence of diabetes in these people who are over forty, need not deter one from doing operations, certainly not operations of necessity, nor in some cases, I think, operations where life was not endangered. One of my cases was a lady æt. about 50, who had an enormous umbilical hernia hanging over the pubes, causing a great deal of distress. Operation had been refused because there was glycosuria. However, again, taking the case as a whole, it did not seem that the glycosuria was doing harm, and so I removed this enormous tumour. There was primary union and she got well; and during her convalescence we could not trace that her glycosuria did any harm. Probably in those cases where the tumour does not become fixed the pedicle is wide; the glycosuria case had a wide pedicle. The others are long rope-like pedicles, and twisting several times because fixed.

I have another very interesting group of three cases where the tumour was in the pelvis. I will give you a description of one of the cases, which may be taken as including the other two. A young lady, æt. 23, was sent to me for an opinion as to her having appendicitis, *i.e.*, whether the appendix should be removed. I was struck by her apparent extreme illness, its degree being greater than could be explained by any recent attack of appendicitis, or even a present attack. The history was that in May, 1902, she had an attack of pain on the right side, associated with a rise of temperature and the presence of a swelling. After about three weeks this swelling subsided, so did her temperature, and she got well. The whole of this attack was carefully observed, and the medical attendant was uncertain as to whether it was appendix or not. When I saw her there was a good deal of tenderness on the right side, and I noticed also that there was pus in the urine. That suggested that the ureter had been blocked, and that there were some disease in her kidney. She also had a cough, which made one think she might be tuberculous, and that she probably had tubercular kidney. Phthisis was found at one apex, and the sputum contained tubercle bacilli, though the urine was free of them. So the possible renal origin of the trouble was rather negative. After some months at a sanatorium she got well and came back, and I saw her again in September of the next year. By this time she had put on two or three stone in weight, and was apparently fit to undergo any operation.

Shortly before I saw her the second time she had a fresh attack of pain on the right side, and operation was decided upon.

As the tumour was well down in the pelvis I thought it better to make a median incision, so as to command the appendix and broad ligament. We found a tumour on the right side deep in the pelvis, closely attached to the pelvic wall, and the appendix adherent to its surface. It became a question as to which was the cause of the trouble, the appendix or the tumour. On raising the tumour up and examining its pedicle before ligaturing it showed distinct torsion, and there were some old coagula in the veins; so I have no doubt her case was primarily one of torsion of pedicle, giving rise to pain and a sudden onset. The appendix and the ovarian tumour were both removed, and she got well, though rather slowly on account of stitch trouble. The appendix was practically healthy.

I have seen her recently, and she has got some serous tubercular pleurisy, and is in a bad way. It was interesting because it simulated disease of the appendix. I do not think that is a solitary case by any means; probably there are a good number of them about. I may mention another one, a patient who was in the ward last year. She came up from Dr. Shadwell, of Walthamstow, for relapsing appendicitis. He said he could not be quite clear that it was appendix, because it lacked some of the characteristic symptoms. There had been several attacks of pain, with temperature, but he could not be certain of a local swelling, though there was resistance and tenderness. Her age was twenty-three. Acting on his doubt, we made an incision through the rectus sheath, so as to command both situations, and we found an ovarian tumour, with the appendix adherent to its upper part. The vessels of the pedicle contained old blood-clot. But the appendix when removed, in both these cases, did not show any constriction or concretion, or any evidence that it had been the seat of disease. I think both those cases were primarily ovarian.

There is a third case, which was in Lydia ward three years ago, with the same trouble.

Another interesting group of three cases I have to mention, namely, of large ovarian tumours, reaching above the umbilicus, and in

one case nearly to the ensiform cartilage. These three cases are very much alike, in that they all had an initial attack of pain and vomiting. Then there was found to be some dulness in the middle line in all of them. This dull area gradually increased. One of the patients, who was in Martha ward some years ago, had had three months' illness, with hectic fever, and when she came she still had it mildly. There were, in this case, all the usual signs of ovarian tumour. It was rounded, and the flanks were free. The abdomen was opened in the middle line, and there presented a green and yellow cyst. It evidently contained blood, and the wall was undergoing necrosis. A large opening was made, and the cyst carefully separated, breaking through delicate adhesions, showing that there was an inflammatory process going on. A most curious point was observed when the uterine attachment was reached. The tumour lay over and was adherent to the uterus and no pedicle could be drawn up. The attachments broke through as one raised the tumour It was clear, therefore, that in this instance the vessels in the pedicle had become thrombosed, and the tumour had been filled with blood. Hence the increase in size and peritonitis. Necrosis of the wall of the tumour was taking place, giving rise to hectic fever. Happily it did not become septic. As the tumour came away there was one bleeding point, but that was soon controlled.

Another case was that of a woman in Mary ward, some three or four years ago. She came from an infirmary where she had been laid up some weeks with an illness attended with fever. It was thought to be a chronic form of inflammation of the appendix, that form which gives rise to a very large solid tumour. One has seen them double the size of the present specimen. My colleague there was so convinced of this being appendix, that he asked me to deal with it in that way. An incision was made in the right iliac fossa, and one came upon a large solid tumour arising out of the pelvis. An opening was made in the middle line, and a very big cyst was seen, green in colour, and containing a large quantity of blood. The pedicle broke through in this case also. This patient also made a good recovery.

The third case occurred in Bright ward and practically the symptoms were the same; an attack of pain some weeks before a gradually increasing tumour with hectic fever. The question is whether, in these large cases, one is right in assuming that the pedicle has been twisted. I think it is open to doubt. All one can say in the case of the large ones is that the circulation through the pedicle has been interrupted. The tumour when operated upon was in all three so enormous, that it seemed impossible there could be room for it to twist round two or three times. Probably in all the tumour was of moderate size, but enlarged after torsions. The pedicle in all three was too much altered to trace a twist.

In these big cases, which form an interesting group by themselves, the question of the wisdom or the necessity of using a drain comes in again. If one is over-cautious and wishes to run no risk, a gauze and rubber drain is quite correct. But if one cleanses the pelvis, I take it there is no necessity for a drain; the inflammatory material left behind can be absorbed by the peritoneum.

These nine cases, in all of which operation was successful, form three groups. First, the type of case where the tumour is high up the pedicle is long and may become twisted two or three times. Sometimes there follows a complete undoing of the twist, and the attack may occur many times, as in the case of the Jewess. In others there may be an initial twist, which fixes the tumour. In such a case the pedicle is long, and the tumour is drawn down towards the pelvis; a tumour which was movable high up becomes fixed low down. Then there is the second group of three cases, where the tumour is in the pelvis, on the right side, the torsion closely resembling appendicitis. The diagnosis would be made by rectal and vaginal examination, which should never be omitted; but there again in appendix cases we may have a tumour which can be felt per rectum and per vaginam. I think probably we should find that ovarian tumours would be larger and rounder and harder, whereas in appendix cases they would be irregular in shape, and the mucous membrane of the rectum would be œdematous. Then there is the third group, of large increasing ovarian tumours associated with hectic fever. One thing you must not do is to aspirate them. It is dangerous in that it is likely to determine septic peritonitis, or septic changes in the cyst.

Early removal is no doubt the best treatment, and there is no necessity to wait for subsidence of the temperature. In the last group the pyrexia had lasted three months.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

A Question of Diagnosis.

"I REMEMBER a somewhat similar occurrence when I was a student," remarked a grey-haired man, contemplatively knocking out his pipe on a projecting angle of the fireplace. There had been a local meeting of the district medical society and the eddy currents of the homeward stream had washed up a few kindred souls into the smoking room of the club. There the talk had drifted from the inevitable further argument on the day's business to an armchair discussion of the psychology of fear. "It is many years ago now, and the impression has lost much of its sharpness, but I don't think I have forgotten any of the essential points. His name was Everard." The speaker paused while he examined the bowl of his pipe with great attention. "Let me see, he was before your time, I think, Howard?" A grunt from an easy chair corroborated this impression, and the grey-haired man settled down with the satisfactory feeling that he was free from all contradictions as to fact.

"There was nothing very striking about the personal appearance of Everard. He was just one of those healthy, well-set-up specimens of young manhood who make the bulk of our student population. Not a big chap, not one of those big-boned giants who break each other up at football for the honour of the hospital, but an ordinary average Englishman. And when I say average I am sure that no one would have suspected that he was more sensitive or more given to introspection than the average medical student. About the last man that you would accuse of being jumpy. He was dark complexioned; that's important as you will see. Yes, he was distinctly dark and caught the sun very easily. We were in the dissecting room together and developed the beginnings of a friendship that might have been lifelong. . . . But it was when we were medical ward clerks that it happened. It was the old story. You all know it. I had phthisis myself, several times, and Hammond of Nottingham had a malignant growth of his cæcum! . . . but that's a digression. Well, we were ward clerks, pretty average ward clerks, I suppose, and Everard had just returned from a holiday. I am certain on that point for I was to have accompanied him, but domestic trouble. . . . He looked very fit when he came back, very fit indeed, and I remember I envied him the rich brown that he had acquired from a September sun. I remember also very clearly now, for I suppose that must have been the beginning of it, that he seemed to find irksome my congratulations on his healthy appearance. I can see now the look he gave me when I used the word bronzed to describe his face—for he was bronzed, that was the only word that can convey the deep tan on his face and neck. Other men evidently noticed the glow of health that he diffused around him, for he complained to me that evening as we were walking homewards together, of the personal remarks to which he had been subjected, all, as he said, because his face was dark. The tone in which he spoke caused me to look at him, and I could discern in his eyes a curious hunted expression which seemed to express a strong mental fear. He staggered at the corner of the street, but protested that he was quite well.

The very next day there was a small operation in the ward, nothing much, a tracheotomy or something, but all the same, to us, an event of the first importance. We were all very keen but Everard was painfully nervous for some little time before. I had to speak to him and insist on his keeping quiet. Of course the inevitable happened, and when the house-surgeon picked up the knife Everard went down in a heap on the floor. I pulled him out of the way and he soon came round. I was rather struck by the first words he said when he recovered himself. "I fainted, of course," he said, "that's what it was, I fainted." And again that look which I had seen when we were walking home together came in his eyes. Only this time the fear was very real. I was rather surprised that he made no attempt to excuse himself for the syncope. Usually one seeks a thousand-and-one reasons for such an exhibition of feminine weakness, but although he had had to my knowledge no lunch that day, he did not offer any excuse but seemed to derive a certain grim satisfaction from the fact that he had fainted. The sister made him some tea and he sat quiet for a bit in her room. I found him gone when I went later to suggest going home. Next day he did not appear in the wards, but I did not anticipate anything other than a rest after his slight indisposition. You see, we did not live together although his rooms were within five minutes' walk of mine. I determined to look him up that evening after dinner to see how he was. But I got a letter from my father asking me to meet him at his hotel that evening, for he had paid an unexpected visit to town and was going back in the morning. So I did not see Everard that night . . . I wish I had, now. The morning's post brought me a letter in Everard's writing. I have still got it at home amongst my papers. It was a most piteous letter. There was the poor chap struggling against himself, against the fear that had come over him and which threatened to engulf him. I remember the letter almost word for word. It began with a reminder of the fit state in which I had fancied him on his return from his holiday and went on to protest that in reality he felt miserably ill and weak. Every time a friend remarked on his fitness he felt the mockery of it all and sought round for a means of escape from himself. It was the chance use of the word *bronzed* that first suggested to him the clue to his whole condition, and the subsequent fear with which he awaited confirmation of his theory had not passed unnoticed by me. That day when he fainted had proved conclusively that the theory was theory no longer, and he dodged home by himself to think, to think, to think. Thus he wrote it, three times, and I felt I could catch something of his fear as he walked home alone.

The next day he went to see Manners, who was then our Senior Physician, and the visit confirmed conclusively

the result of his own introspection. You may remember Manners. A most kind and gentle sort of fellow who hated to hurt anyone's feelings. If you knew him you could imagine the ceremony and attention with which he must have listened to poor Everard's faltering speech. All the while wondering how he might politely tell him to go home and not make a fool of himself, for he was as sound as a bell. That politeness of manner was unfortunate . . . for Everard. He, poor fellow, only saw in it the confirmation of his fears. Now, if he had only gone to Browne . . . Well, the tone of Everard's letter was such that I did not wait for my breakfast but went round to his rooms at once. "He was in," the landlady said, "and had not yet risen." Here the grey-haired man paused to relight his pipe and then puffed dreamily in silence for some moments. "Dead?" asked one of his auditors. "Yes; gone through his right femoral with a razor and had been dead some hours. In his sitting-room I noticed a medicine book open at the Treatment of Addison's Disease, and I suppose that after writing to me he had started brooding again and the fear had come over him." There was a silence for some little time, then Howard asked, "Who was right, for I suppose you had a post-mortem?" The grey-haired man rose and knocked out his pipe. "Oh, Manners, of course. The body was absolutely healthy. It was funk, sheer funk, that's all." S.

Princess Christian and the Ladies' Association.

THE ninth annual general meeting of Guy's Hospital Ladies' Association was held in the Court Room, Guy's Hospital, on Saturday, May 28th. The President of the Association, H.R.H. Princess Christian, was present at the meeting, and was received by Mrs. Benyon and Mrs. Como Bonsor. Amongst the members who signified their intention of being present were the Countess of Selkirk, the Countess of Bective, Lady Edward Spencer Churchill, Lady Arthur Hill, the Hon. Mrs. Talbot, Lady Perry, Lady Fripp, Mrs. Frederick Taylor, Mrs. Galabin, Mrs. Hale White, Mrs. Symonds and Miss Swift, the Matron of the Hospital. Before the meeting the following ladies, as Secretaries of local branches, were presented to Her Royal Highness:—

Mrs. Thorpe, Clapham Branch.

Mrs. Bramley Taylor, Denmark Hill Branch.

Mrs. White, President, Miss Willson, Secretary, Dulwich Branch.

Mrs. Layton, Hampstead Branch.

Mrs. Beven, Lee Branch.

Miss Daniel, East Norfolk Branch.

Mrs. Edwards, Woodford Branch.

The minutes of the last general meeting having been read and signed by Her Royal Highness as correct, Mrs. Pye-Smith, the Honorary Treasurer, presented the accounts, which, on the motion of Lady Perry, seconded by Mrs. White, the President of the Dulwich Branch, were adopted.

The annual report was then read by the Honorary Secretary, Mrs. Lauriston Shaw. Attention was drawn to the increased success of the Association during the past year under the presidency of Princess Christian. The report contained a recommendation from the Committee that £150 should be voted from the funds to support three beds in the Maternity ward. It was announced that two new branches had been instituted during the year, and that the number of garments made by members of the Association for the use of patients had considerably increased.

The adoption of the report was moved by Mrs. Benyon, who said:—Your Royal Highness and Ladies,—Before moving the adoption of the report I should like to make one or two remarks. I should like to thank Her Royal Highness for consenting to become our President. I am sure her interest will do the Association a great deal of good. This is the tenth year of the Association's work and its members now number 761, showing an increase of 94 new members this year. We (the Committee) again think we should give the Treasurer of Guy's Hospital £150 for the support of three beds in the Maternity ward. We have done this for three years, but to enable us to do so next year we shall require additional support. It is therefore necessary for us to make the Association more widely known and to obtain as many new members as possible. Our aim in the future is to support all the eight beds in Victoria ward. The branches are in a very satisfactory condition, they are really the main spring of the Association, for out of a total number of 761 members, nearly 500 are connected with the various local centres. Over 8,000 in-patients pass through the wards each year, so that it will be seen that a very large number of garments are required. The financial position of the Association is very satisfactory, the annual subscriptions showing an increase over last year. The amount received from the branches is £17 more this year, and we have also received a donation of £10 from the Countess of Selkirk; the expenditure has been very much the same. Our thanks are due to the Hon. Secretary and Hon. Treasurer for their untiring energy, and to Mrs. Hale White for auditing the accounts. I have much pleasure in moving the adoption of the report and that it be printed and circulated.

The Matron, who seconded the adoption of the report, said: I have much pleasure in seconding the adoption of the report and should like to say that the Association is the greatest help to the work of the Hospital, not only in providing garments for the use of the patients in the wards, such as flannel jackets, but also in providing things both useful and ornamental in ward equipment. Last year our average number of beds occupied each day by poor patients was 500, and with very few exceptions the Samaritan cupboard of this Association was able to supply the Sisters with what they required for sending patients suitably clad to convalescent homes, etc. The work of the Lady Visitors is also much

appreciated by the patients, Sisters and myself. I am glad of this opportunity of thanking each member of the Association for her valuable help.

The reports of the fourteen local branches were read and proved that all were in a highly satisfactory state. The Countess of Bective and Mrs. Arbuthnot Lane were elected to fill the vacancies on the Committee caused by the retirement of Lady Gull and Miss Swift. A vote of thanks to Her Royal Highness for her kindness in presiding was moved by Mrs. Benyon, seconded by the Countess of Bective, and carried with acclamation.

Her Royal Highness, in replying to the vote of thanks, said: I am extremely obliged to you all; it has been a great pleasure to me to be present; I only wish I had done more to help the Association, but shall hope to do better this year.

After the meeting Her Royal Highness inspected the needlework contributed during the year, and was entertained at tea by Mrs. Benyon, the Vice-Presidents, Executive Committee and Local Secretaries being also invited. Before leaving, Princess Christian visited some of the Hospital wards.

Guy's Hospital Clubs' Union.

REPORT, 1903—1904.

The Council of the Clubs' Union beg to present the Twelfth Annual Report of the progress of the Union, together with a statement of Receipts and Expenditure for the year ending 31st March, 1904. The membership of the Union continues to increase, the increase this year being 80, against 155 last year. The total membership of the Union in now 2431, of whom 2154 are Life Members, 232 Subscribers, 39 Patrons, and 6 Honorary Members. The continued support accorded by the Governors and Staff of the Hospital and old Guy's men is especially gratifying to the Council, since the income of the Union from the subscriptions of members is still insufficient to meet the ordinary expenditure.

We again venture to point out to old Guy's men who have not paid their guinea subscription for Life Membership, the advantage of having their names and addresses in the Clubs' Union Blue Book, which is a useful directory, and is much used by members who wish their patients, when away from home, to be looked after by Guy's men.

In the last report, the Council expressed the belief that the new method by which subscriptions are now paid (*vide* Rule 16) would shortly result in such an increase of income as would once more place the finances of the Union on a satisfactory basis. The experience of the past year tends to strengthen this belief, the amount received from annual subscriptions having increased by £149 2s., and moreover it is hoped that a considerable further increase will result during the next year. The expenditure during the past year has been £170 13s. 7d., in excess of income. This in great part is accounted for by the unavoidable expenditure of £100 14s. 1d. upon the paving of Brockley Rise and the laying down of new drains. Under ordinary conditions the actual loss on the year's working would therefore have amounted to £59 19s. 6d. This amount should be more than balanced by the increase in subscriptions during the next year.

The Council has great pleasure in announcing that during the coming autumn, a covered stand will be erected upon the ground at Honor Oak Park. The cost of the stand will be defrayed by an advance made, free of interest, to the Clubs' Union by the Gazette Committee for this special purpose, and the Council takes this opportunity of expressing its thanks to the Gazette Committee for the cordial manner in which they met the proposals of the Council with regard to this matter. The increased accommodation afforded by the stand should result in a considerable further increase in gate receipts, which were more than doubled during the past season, owing largely to the excellent work of the Advertising Agent, Mr. W. King Rist, to whom the thanks of the Council are due.

The best thanks of the Council are due to the officers of the Constitutent Institutions, to the Auditors, and to Mr. Croucher, for their assistance.

(Signed) CHARLES HIGGENS, Chairman.

Statement of Receipts and Expenditure from April 1st, 1903, to 31st March, 1904.

1903. RECEIPTS.	£	s.	d.	£	s.	d.
April 1.						
To Balance at Bank	101	3	5			
Less Petty Cash o/d	0	1	5			
				101	2	0
1904.						
March 31.						
To Annual Subscriptions ...	499	16	0			
„ Composition fee for Life Membership	3	3	0			
„ Subscriptions—Gazette and Reports ...	235	3	6			
„ „ from Patrons	40	4	0			
				778	6	6
„ Grant from Medical School...	100	0	0			
„ „ Dental School ...	20	0	0			
„ Rents from Tenants	107	10	0			
„ „ Lockers	12	0	0			
„ Year Book Advertisements ..	63	11	0			
„ Gate Receipts...	51	6	6			
„ Sale of Railway Tickets ...	66	7	0			
„ „ Season „ ...	0	5	0			
„ Amount received per Mr. Noakes for Fencing ...	13	2	6			
„ Special Donation from an Old Guy's Man	0	8	6			
				434	10	6
To Deficit, being balance due to Bank...				69	11	7
				£1,383	10	7

1904. EXPENDITURE.						
March 31.		£	s.	d.	£	s. d.
By Grants to Constituent Institutions—						
Rugby Football Club	...	28	10	2		
Association Football Club		9	13	7		
Athletic Club	... ...	30	0	0		
Lawn Tennis Club...	...	17	6	9		
Physical Society	... ...	26	0	0		
Christian Union	... ...	3	0	0		
Rifle Club	... ...	8	0	0		
Dental Society	... ...	8	16	0		
Debating Society	... ...	3	4	1		
Guy's Hospital Gazette	...	213	17	6		
„ Students' Club	...	198	9	6		
					546	17 7
By Clubs' Union Year Book	...	95	14	3		
„ Secretarial Expenses	...	30	5	10		
„ Railway Ticket deposit a/c	...	54	7	0		
„ Printing and Stationery	...	6	1	9		
„ Field Rent a/c	... ...	218	10	0		
„ Rates and Taxes	... ...	99	2	2		
„ Paving Brockley Rise	...	52	0	9		
„ Cost of connecting up with New Sewer	... ...	48	13	4		
„ Field Current Expenses	...	229	19	4		
					834	14 5
„ Petty Cash Balance in hand					1	18 7
					£1,383	10 7

Audited and found correct.

R. P. ROWLANDS,
C. D. PYE-SMITH.

FRANCIS J. STEWARD, Hon. Sec.

The Wills Library.

THE Committee are revising the periodical literature received in the Wills Library. They have recently decided to discontinue the purchase of certain publications, of which there have been in the past but few readers. They will shortly consider the advisability of substituting, for those omitted, other periodicals of more general interest. For this purpose the assistance is asked of readers of the GUY'S HOSPITAL GAZETTE. Below is set out the recently revised list of periodical literature (exclusive of annual reports, calendars, &c.), purchased by or presented to the Library. The Committee would be glad to receive the names of weekly or monthly professional journals which any present or past student of the Hospital believes would be of educational value to the readers in the Library. Suggestions should be sent to the Librarian, Wills Library, Guy's Hospital, or may be entered in the book kept for the purpose by the Librarian, and the proposed additions will be considered at the next quarterly meeting of the Committee.

REVISED LIST OF PERIODICALS.

Annals of Surgery.
Archives Générales de Médecine.
Brain.
British Medical Journal.
Clinical Journal.
Dental Cosmos.
Journal of Physiology.
Journal of Anatomy and Physiology.
Journal of Bacteriology and Pathology.
Lancet.
Virchow's Archiv.
American Journal of the Medical Sciences.
Bristol Medico-Chirurgical Journal.
British Dental Journal.
Birmingham Medical Review.
Dental Record.
Dublin Journal of Medical Science.
Glasgow Medical Journal.
Journal of the Royal Army Medical Corps.
Johns Hopkins Hospital Bulletin.
Liverpool Medico-Chirurgical Journal.
Medical Chronicle.
Medical News (American).
Zentralblatt für Chirurgie.
Zentralblatt für Klinische Medicin.
Medical Review.
Pharmaceutical Journal.
Practitioner.
West Lond. Med. Journal.
Australian Medical Journal.
Annales de l'Institut Pasteur.
Archives de Physiologie.
Le Progrès Medical.
Revue de Médecine.
Upsala Läkareförenings Forhandlingar.
Gaceta Medica de Costa Rica.

PRIZE COMPETITION.

In connection with the above notice which we have inserted at the wish of the Wills Library Committee, we have decided to invite our readers to take part in a competition which will increase their knowledge of professional periodical literature and assist the Library Committee in selecting medical journals for the Library.

The winner of the competition will receive a prize of two guineas (£2 2s.).

Competitors are required before June 24th, to forward to the Editor two lists of professional periodical literature. The first list is to contain the names of all the periodicals in the list published above, arranged in the order which the competitor regards as their order of indispensability in a medical student's library.

The second list is to contain the names of the ten professional periodicals not contained in the above list which the competitor regards as most suitable to supplement or replace periodicals already received in the Library.

The ideal order of the existing list and the best ten additional periodicals will be decided by the vote of the majority of competitors, and the competitor whose results most nearly correspond with the views of the majority will be awarded the prize.

The decision of the Editor in all matters connected with this competion shall be binding upon every competitor.

In Lighter Vein.

THE POISONER.

MR. CUMBERPATCH had tasted connubial bliss to repletion. He was, to use a vulgar expression, fed up to the neck with domesticity. His wife's waning charms, her commonplace comments on things in general, and her occasional excursions into Christy Minstrel humour, all combined to exasperate him. Married life daily become more insupportable, and Mr. Cumberpatch cast about for a means to end it. The Divorce Court offered an easy solution of the problem; but Mr. Cumberpatch had been carefully brought up, and the idea of a divorce was repugnant to his religious and moral convictions. So he determined to poison his wife.

He had had no training in toxicology, and, not being related to a coroner, he had no opportunity of becoming an *ex officio* expert in the science. But still he knew enough to be aware that arsenic was a pretty reliable drug, and one held in high esteem by poisoners of experience and repute.

Accordingly he sought out a chemist and purchased some arsenic of a superior brand, warranted free from impurities, and never known to fail in the most obstinate cases. This he carefully added to his wife's food and committed the issue to the hands of Divine Providence.

The effect of the arsenic soon appeared in Mrs. Cumberpatch's feeble constitution. She certainly grew paler, but her appetite improved and she declared that she had never felt better in her life.

Cursing the arseniates which had disappointed his fond hopes, Mr. Cumberpatch decided to change the drug. He had always heard corrosive sublimate well spoken of, and determined to give it a trial. He again repaired to the chemist's and demanded ten grains of chloride of mercury.

"Ten grains!" said the chemist, with a knowing smile, "that ought to do the business."

Fortified by the chemist's assurance, he took home the powder and surreptitiously slipped it in his wife's supper beer.

But as Mr. Cumberpatch had omitted to mention which chloride it was he wanted, and as druggists always know your requirements much better than you do yourself, what Mr. Cumberpatch got was ten grains of calomel. Now the arsenic had given Mrs. Cumberpatch such an appetite that she was in serious danger of stomach troubles from over-eating. This danger the calomel effectually removed, and Mrs. Cumberpatch's health continued to improve. Invoking the wrath of Heaven upon the head of the man who invented corrosive sublimate, the unfortunate Mr. Cumberpatch once more sought the chemist and bought some opium. This checked the somewhat excessive action of the calomel and moreover completely cured his wife of the insomnia to which for years she had been a martyr.

Forswearing toxicology for ever as chicanery and charlatanism, Mr. Cumberpatch was at his wits' end for a reliable means to rid himself of his spouse, when, one day at lunch, she suddenly turned giddy, became blue in the face, and fell unconscious on the floor.

Obviously she was moribund; but to make assurance doubly sure her joyful husband seized the carving knife and dealt her a terrific blow.

The resulting hæmorrhage quickly revived her, and she made a complete recovery.

Poor Mr. Cumberpatch! Seeing that every attempt on his wife's life merely prolonged her days, he determined to oppose no longer the obvious will of Providence, and himself sought death. But the lessons learnt at his mother's knee had been deeply ingrained, and he knew that suicide was immoral and ungentlemanly. So he went to the nearest County Council mortuary and claimed admission as a voluntary boarder.

Special Notice.

WE have been asked to draw particular attention to an advertisement of the Holborn Surgical Instrument Co., Limited, which appears on page 3 of our advertisements. Those about to make a start in practice should be specially interested, for the Company is making an effort to meet the immediate requirements of the young surgeon in the most moderate manner possible as regards expense and with a nice sense of the instruments that are absolute necessities.

Reviews.

The price of books submitted for review should in every case be stated.

Notes on the Composition of Scientific Papers. By T. Clifford Allbutt, M.R.C.P., F.R.C.P., etc. (Macmillan, 1904). pp. 154.

A year or two ago a Cambridge man at Guy's, having been ploughed in his M.B. examination, had the temerity to write to Professor Clifford Allbutt to ask if an explanation of his failure could be given him. The answer of the Regius Professor of Physic was short, concise and crushing; it was to the effect that the candidate's answers were too "prolix, verbose and garrulous." This ended the correspondence. Having now for some years endured in comparative silence a flood of "prolixity, verbosity and garrulity," Professor Clifford Allbutt has embodied the results of his experience in a few short chapters of advice to intending writers of theses.

The greater part of the book is devoted to errors in style and grammar, for though the material of the theses is occasionally poor, their style is almost invariably execrable. Now style is the mechanics of literature, and unless a man take some pains to achieve a mastery of his own language, he will remain comparatively unattractive and inarticulate, and the truth will suffer in its expression.

As Robert Louis Stevenson says, "l'art de bien dire is but a drawing room accomplishment, unless it be pressed into the service of the truth. The difficulty of literature is not to write, but to write what you mean; not to affect your reader, but to affect him precisely as you wish. This is commonly understood in the case of books or set orations; even in making your will, or writing an explicit letter some difficulty is admitted by the world. But one thing you can never make Philistine natures understand; one thing which yet lies on the surface, remains as unseizable to their wits as a high flight of metaphysics—namely, that the business of life is mainly carried on by means of this difficult art of literature, and according to a man's proficiency in that art shall be the freedom and the fulness of his intercourse with other men. Anybody, it is supposed, can say what he means; and in spite of their notorious experience to the contrary, people so continue to suppose."

If any man would like to see how every time we grasp a pen and put it to paper we commit errors in grammar and style, solecisms, tautologies, false concords, split infinitives and other crimes of writing, let him get Professor Allbutt's book (it is but a small one) and read it from cover to cover. We have done so with much appreciation and more pleasure, and could wish a copy in the hands of every man whose duty it is to describe present conditions for future readers.

Medical Monograph Series. No. viii. Insanity. By E. J. Younger, M.D. (Ballière, Tindall & Cox.) 2s. 6d. net. pp. 109.

Half the book is devoted to definition and causes of insanity and the examination of the patient in which good plain advice is advanced to a professional man about to interview a suspected lunatic. The other half, given up to description of general and special types of insanity, is clear, succinct and concise. The whole book is short, compact, and omits no essentials.

Bacteriology of Every-day Practice. Vol. ii. By J. Oding Symes, M.D., D.P.H. 2s. 6d. net. pp. 108.

This subject does not lend itself to treatment in the short space allowed in this series. That anyone would receive assistance in the recognition of organisms from this volume is indeed doubtful.

Diseases of the Appendix Vermiformis and their Treatment. By F. J. Lloyd, M.R.C.S., etc. (John Bales, Son & Danielson.) pp. 37.

This a reprint from various medical journals, has little to recommend it. It lacks originality both in matter and treatment of subject. The ordinary text-books give as much information and in a less verbose and shorter manner. Errors in spelling and looseness in phrasing are to be met with.

Husbands' Forensic Medicine—Toxicology and Public Health. 7th Edition. By R. J. M. Buchanan and E. W. Hope. (E. & S. Livingstone) pp. 724. 10s. 6d. net.

This popular text-book is now enlarged, illustrated, and brought up to date. We note in the Forensic part, additions of fresh matter on Blood-stains; in the Toxicology, the presence of food poisonings and their effect.

Although the Public Health division, in previous volumes always the weakest part of the book (in fact we have often maintained that it should be omitted so as to reduce the size of the volume), has been almost entirely rewritten, still it is doubtful whether this part of the book will ever be read since there are so many good short works on Public Health.

The addition of numerous illustrations considerably enhances the value of the book, the success of which ought to be assured.

Lateral Curvature of Spine. By J. Steele Perkins, M.D. (Bemrose & Sons, Limited.)

A pamphlet, printed from a lecture, quite worth reading, and setting forth the author's experience in treatment of this affection.

He advocates exercises and rest in good positions.

Clinical Studies in Syphilis. By Arthur H. Ward, F.R.C.S. (The Medical Times, Ltd.) pp. 156. 3s. 6d.

An admirably lucid little work on syphilis. All the various manifestations and phenomena of the disease are explained on "The Microbe Toxin Theory" that there is an organism unknown which spores and gives rise to a toxin in the body. Latency in manifestation of lesions is attributed to spore-formation or the small quantity of the original infection.

The book gives us no fresh information as to first causes, but it makes the whole disease more compact and more easily comprehended when each symptom can be brought to one theoretical origin.

The treatment and the social aspect of syphilis are also discussed.

The author, judging from the clinical part of the book, appears to have acute powers of observation and to describe lucidly that which he has observed.

Guy's Hospital Debating Society Dinner.

ON Tuesday, May 31st, Dr. Savage took the chair at 7 o'clock, supported by Dr. Fawcett, Dr. Eason, Mr. Ormond, Mr. Ogle, Dr. French, the President of the Residents, and about 60 members.

After the King's health had been proposed and duly honoured, Dr. Savage proposed the health of the Debating Society in a few words, and, after we had drunk "to our noble selves," he again rose to give us his promised reminiscences as a general practitioner in an extremely amusing speech which was all too short, and made us hope that successive dinners would enable him to give us some of his later experiences. For if three-quarters of an hour's reminiscences were the result of four years' general practitioner's work—strange and extraordinary as that was in many respects—a week would hardly suffice to contain all the speaker's many experiences of the remaining thirty-six years' practice as a mental specialist.

Dr. SAVAGE prefaced his speech by a few remarks on the advantage of knowing how to talk. Man, he said, is a reasonable animal, but he rarely exercises that special function, and when called on to "think in public" is often unable to do so, as he has not learnt to be indifferent to his surroundings. The speaker feared that with advancing years came an advancing tendency to talk; and that, as he was approaching "the wrong end of life," he had reached the stage of babbling talk; what he lost in force he gained in volubility, but as President of the Club he was required to talk, and accordingly ventured to give us his experience of forty years ago as a general practitioner. It was as an impecunious ex-house-surgeon of Guy's, in search of work, that he was offered an appointment as medical officer to a lead mining company in Cumberland, whose offices were in London, the terms being £250 a year, with horses and house provided, permission to get what general practice he could, and holidays when convenient. It was a good chance; it was necessary to work to live, so the offer was accepted and a start was made. He arrived at Holtwhistle, a small station on the Carlisle to Newcastle railway, whence a small branch line ran to Alston, from which his district stretched for five to ten miles—more lead mines than lead. There were two large villages, each of about a thousand inhabitants, and separated by a high hill which had to be crossed every time an excursion was made from one to the other; and, when he arrived, snow lay on the ground three or four feet deep.

Never had he known a better managed village, the system of government being an autocracy, with its seat in London; it was well supplied with schools, to which every child had to go, and there was a library; while drunkenness to any large extent was unknown. He never regretted having accepted the post, as he had to treat a thousand and one different maladies absolutely unaided, for it is a great advantage for a young man—as Mr. Bryant pointed out—to know that no consultant is anywhere near to help. The company encouraged small speculations among the men, so that the surrounding country was split up into small farms, many of them fifteen miles off, and often requiring a daily visit, for, as there was nothing to pay, the medical officer had the advantage of seeing everything. There was plenty of exercise; seeing that in addition to the daily riding, there were crags to climb, and a gun and a dog provided good sport on the moors, which belonged to the company.

The miners were so hospitable that all the previous doctors had taken to drink, so his safety lay in milk alone.

In the winter his favourite method of progression was on a pair of *skis*, the use of which has lately been reintroduced; on one of his last expeditions, a boy was bribed with twopence to carry the skis to the top of a hill separating the two villages, while Dr. Savage walked up, and, having adjusted them at the top, commenced his descent, but losing his balance on some ice, and meeting Farmer Archer's cow at that moment, he embraced its tail, and the pair descended into the village in very close company.

One of his horses had been a racehorse, so that he was credited with many feats of daring in the surrounding country. On one occasion his bridle was seized at a turnpike, and he was requested to pay double; on demanding an explanation he was assured that "last time you leaped the gate—it must have been you, for there is nobody else in the county who could do it!"

The men were very hard worked, and nearly all died of miner's phthisis; the local aversion to post-mortem examinations was very strong, but it was considered an honour if the medical man attended the funeral: which was announced by two or three of the neighbours going the round of the village and beating on the doors with a stick, the usual formula being "You are bidden to the funeral of Mr. X., and the corpse will be lifted at twelve o'clock." He resolutely refused to attend unless he was allowed to make a post-mortem, and was thus enabled to see the state of the lungs, which were covered with adhesions. The disease was evidently not merely due to mechanical irritation, but was often transmitted from husband to wife. Goître was very common—in women more than in men—and even amongst the lower animals, especially dogs. Its relation to the water supply was most marked, those supplied by a spring from limestone were affected, while, if sandstone supplied the water, goîtres were unknown.

The villagers had a great horror of infectious diseases, and in one very severe case of variola he had to visit and feed the patient; and was only allowed to enter other houses when enveloped in a waterproof coat; the patient died, and, as the undertakers refused to help, he had to measure the corpse, screw down the coffin on its arrival, and envelope it in sheets saturated with "disinfectants" before they would "hurl" it to the grave.

It was fortunate that there was but little surgery, for his only instruments were his pocket dressing case, and an amputation had to be performed with a saw borrowed from a friendly butcher,—the stump healed by first intention (loud and prolonged applause), and on his—the speaker's mother—visiting the village, the patient waved an artificial arm in her face with the equivocal statement "your son did this, ma'am."

On one occasion he amputated at the ankle-joint single handed, acting also as his own anæsthetist, the intervals of the operation being filled up with artificial respiration—the patient lived and grew fat (cheers).

On his arrival a certain John Brown had a great reputation as a bone setter, which, however, he soon lost, as certificates of capability to work were not forthcoming from the new doctor for any of John Brown's patients.

Many serious accidents were caused by the men insisting on ramming home the charge of gun-cotton with an iron "pricker," instead of the copper one provided for that purpose.

Midwifery, however, formed such a large portion of his practice—500 cases in four years—that he developed hallucinations of hearing, and often answered the night-bell when it had not been rung. On one occasion, when craniotomy was necessary, the neighbouring medical man refused to give chloroform, as he had never even seen an anæsthetic given, so confined his assistance to kneeling and praying in one corner of the room, where he remained throughout the operation; the other corner being occupied by the "nurse," who had fainted soon after the proceedings commenced.

The first child was often christened George Henry Savage, etc., and had to be toasted as such by the medical man; this custom nearly causing a catastrophe, as on one occasion a glassful of paraffin was offered by mistake, and swallowed at a gulp.

The local doctor was often required to take the chair at the meetings of various sects, and, being catholic in his tastes, he consented, until one sect put him in the pulpit and prayed for his salvation.

The speaker concluded by pointing out the advantages of good all-round work such as he had in Cumberland and which did not prevent him reading for his M.D.

Mr. ORMOND proposed a hearty vote of thanks, which was accorded with much acclamation; and Dr. Savage in acknowledgment asserted that he had passed old Age, and reached Anecdotage, where he hoped to remain. He felt sure that a doctor's tales could be hardly less interesting than those he had heard from fishermen of fish lost, or than the yarns of those afflicted with that new disease, Golf Jaw.

The Diagnosis and Treatment of Coma.

AWARDED THE PHYSICAL SOCIETY'S PRIZE.

(Continued from our last issue.)

A paper read before the Physical Society on Saturday, February 27th, 1904, by N. I. SPRIGGS.

DIAGNOSIS OF COMA.

We will now briefly recapitulate the most distinct features of each class of case, from a diagnostic point of view.

Apoplexy.—Profound coma, of sudden onset, in an elderly man, with thick arteries, and possibly signs of hemiplegia.

Compression.—History of injury, with lucid interval following, succeeded by profound coma, with possibly one pupil dilated, or hemiplegic signs.

Concussion.—History of injury immediately succeeded by a less profound coma, with pale face and feeble pulse and respirations.

Epileptic coma.—History of previous fits or of convulsions preceding the coma; most probably a young subject with possibly a bitten tongue. Rapid improvement.

Epileptiform attacks of G.P.I., cerebral syphilis, disseminated sclerosis, or cerebral tumour cannot possibly be diagnosed from epilepsy while comatose.

Uræmic coma.—Coma, with intermittent convulsions or twitchings—other signs of Bright's disease.

Diabetic coma.—History—gradual onset—glycosuria—respirations—smell of breath.

Opium poisoning.—Pin-point pupils—ashen hue—history.

Heat stroke.—History—and hyperpyrexia.

Alcoholic coma.—Here the history will be of little or no importance. Alcohol will be left when the other causes mentioned above have been excluded.

From the above summary it will be seen that by far the most important point is, if possible, to get a *correct history.*

From the history and the appearance of the patient, it will be in most cases tolerably easy to make a probable diagnosis.

From the nature of the case, the history is just what we often cannot get. Therefore we must proceed without this help. The following points are placed in what seems to be the order of their practical utility:—

1. *Ascertain the depth of the coma.*—If the patient cannot be roused at all, by any stimulus, for an interval of a quarter of an hour, the probabilities are that he is suffering from an organic lesion, *i.e.*, apoplexy, embolism, thrombosis, or compression. One of the most efficient ways of getting a reaction is to press on the supra-orbital nerve. In connection with this I will read part of a letter which appeared in the *Lancet* in 1882, from Von Wedekind, of the U.S. Navy, who had been "on emergency service" in New York City. He says, "By

pressure on the supra-orbital notches, compressing the nerve, a diagnosis of alcohol may with absolute certainty be made in a few seconds, thus differentiating on the spot, coma due to alcoholism, injury, or disease. Where no result is obtained we may, with almost positive certainty, look for some other cause of coma. In no case have I failed with this method; and so certain have I become of its infallibility, that, without waiting to further examine for head injury, where no result was obtained, I took the patient to the hospital, sure of a 'case.' Be the coma ever so deep, the effect of the alcohol will for a short time be sufficiently removed to permit of a thorough and rapid examination." He also recommends it for hysteria and malingerers.

This sounds to us rather American, to say the least; but I intend in the future to give the method a more thorough trial. I remember a man who was brought in by two policemen when I was dresser for the week. They supposed him to be a malingerer, and all the while they had been bringing him, about a mile, they had been applying homely restoratives, such as pulling his moustache and hair, etc. I vigorously applied the supra-orbital test, and also separated a finger-nail from its bed somewhat by pushing my nail in—all to no effect, he gave not the slightest response. As he had normal reflexes, pulse, temperature and respirations, the stomach-pump was used, and before it was halfway down he was quite sensible. It transpired that he had stolen a gold pin and was wanted by the police, so feigned illness to escape their clutches.

The inhalation of strong ammonia has also been recommended for alcoholic coma, but may be carried too far, especially if the case is not one of alcoholism.

Of course in any of the forms of coma no response *may* be obtained, but if the coma is so very deep, think first of organic lesion.

2. *Look at the patient himself.*—If young, think of epilepsy. If young and thin, with dry skin, think of diabetes. If more elderly and full blooded, think of apoplexy or uræmia. If a young woman, think of syncope and hysteria. Of course these are all only probabilities, but it is by putting many probabilities together that we arrive at a diagnosis, and I suppose that the difference between a good diagnosis and a bad one, is that one is more probable than the other. Examine the head also for injuries; in the great majority of cases of concussion or compression quite definite signs will be found. If the head has been shaved, in a difficult case, the absence of any sign of trauma will speak more against compression or concussion than the presence of a slight lesion will speak for them, as many apoplectic and drunken persons knock their heads in falling down.

3. *Examine for any signs of hemiplegia or monoplegia*, or for one-sided rigidity. Hemiplegia, if found in a "suitable" patient, will usually decide the diagnosis. In a young patient suspect embolism and examine the heart. In an older patient suspect apoplexy. In any patient think of meningeal hæmorrhage, and look for a lesion, but remember its rarity. It must be remembered that uræmia or any epileptiform attack may, very rarely, cause a transient hemiplegia.

4. *Next examine the eyes.*—The state of the conjunctival, corneal, and light *reflexes* will simply be of value as showing the depth of coma.

The *pupils.*—If dilated think of concussion, uræmia, alcohol, or simple syncope. If tightly contracted, opium, pontine hæmorrhage, heat stroke, or rarely alcohol. If unequal, do not pay too much attention to them, as epilepsy, alcohol, uræmia, or concussion may cause unequal pupils, as well as cerebral hæmorrhage or compression. If, however, one pupil only is widely dilated, insensitive and fixed, think of compression at once. If both pupils are dilated widely and fixed, think of organic lesion. If the pupils dilate upon stimulation and then contract again, alcohol is probable. If they vary from time to time spontaneously, think of epilepsy.

As regards *conjugate deviation.*—It has been said to be pathognomonic of cerebral hæmorrhage. This is incorrect. I have seen it in a case of subdural hæmorrhage, but it is undoubtedly very strong evidence for apoplexy.

5. *The pulse* is slow and full in apoplexy and compression. It is slow and feeble in opium poisoning, concussion (early stages), uræmia, and embolism. In any of these cases it may get rapid before death. It is usually rapid in syncope, epilepsy, alcohol, and diabetes.

6. *Respiration.*—This is usually definitely stertorous in cerebral hæmorrhage or compression. It is often stertorous in deep alcoholic coma, in heat-stroke, and in uræmia. In the latter it is said to have a peculiar hissing quality. It is shallow, and perhaps sighing, in concussion and in opium poisoning. In epileptic coma it may be irregular and gasping. In diabetic coma it may be very slow and deep, or rather quicker and noisy.

7. *Temperature.*—This is usually subnormal in coma. It soon begins to rise after a large hæmorrhage, and also rises with the pressure in meningeal hæmorrhage. There may be hyperpyrexia in large ventricular hæmorrhages, in pontine hæmorrhages, or in heat-stroke. After epileptic convulsions it is often raised. Unequal temperatures on the two sides may be a valuable sign, when hemiplegia cannot be discovered. The diagnostic value of the temperature is not usually great. On the other hand it is of great value for prognosis; a very rapid rise, or no rise, being bad signs.

8. *Convulsions.*—If these are present, think at once of an epileptiform attack. If they are repeated it is strongly in favour of uræmia, but the status epilepticus must be thought of; convulsions or twitching may rarely be associated with any of the other forms of coma.

9. The *urine.*—A little albumen is of no value diagnostically. Much albumen with epithelial casts speaks strongly for uræmia. A case is recorded where the urine went almost solid (on boiling) with albumen, for a short time only. It was after a very large dose of alcohol. Sugar, if definitely found in quantity, makes diabetic

coma probable. A small quantity of a reducing body is found in many head conditions.

10. The *tongue* is often found bitten in epileptiform attacks. It may be large, red and dry in diabetes. It is often exceedingly foul in uræmia. If protruded to one side, it is a sign of paralysis of that side.

11. The *heart* will be found to be hypertrophied in apoplectic cases, or in uræmia. Bruits may be heard, pointing to embolism.

12. If the case still cannot be diagnosed, the stomach should be washed out and the gastric contents submitted to *analysis*.

13. The state of the *sphincters* does not help much, except as showing the depth of the coma. A very full bladder or very low specific gravity urine, points of course to alcohol.

14. The same may be said of the *reflexes*.

Inter-diagnosis of organic lesions.—This rests very largely on the history. If there is a history of injury causing concussion, followed by a lucid interval and then on-coming coma, compression is pretty certain. Therefore in many cases where no history is available we cannot diagnose compression except by the scalp lesion, if present.

Five other points may be noted:—

(*a*) In meningeal hæmorrhage we ought to be able to trace the course of the effused blood creeping over the motor area, by the associated paralyses.

(*b*) Meningeal hæmorrhage is likely to progress to a fatal issue if untreated; whilst intra-cerebral hæmorrhage sufficient to cause coma often recovers.

(*c*) The Hutchinson pupil is more characteristic of meningeal hæmorrhage.

(*d*) Conjugate deviation is much more frequent in cerebral hæmorrhage.

(*e*) Crossed hemiplegia will not occur in meningeal hæmorrhage.

In this connection a case may be alluded to which was in John a few days ago.

Patient was a man aged 60, but looking older. He was said to have fallen from a scaffold. He was admitted comatose with stertorous breathing, and involuntary evacuations. Pulse 100, of high tension. Temperature 96·8°. Respirations 20 and stertorous. There were signs of right facial paralysis. Both arms and legs rigid and jerking, but could be moved. Knee-jerks normal. Plantar reflex extensor. No superficial reflexes. Conjugate deviation to the left. The pupils went through the whole cycle supposed to be characteristic of unilateral compression, the left pupil contracting and then dilating, and the right following suit a little later. Finally they were both dilated and fixed. Cheyne-Stokes' breathing supervened before death. Most would agree that this case was one of cerebral hæmorrhage, yet if there had been a clear history of concussion followed by a lucid interval, and especially if there had been signs of trauma on the left side of the skull, I think any surgeon would have considered it right to trephine on the left side.

As it was the diagnosis proved correct at the autopsy, there being a left capsular hæmorrhage, the blood having also got into the ventricles, and so caused the bilateral spasms.

In *subdural hæmorrhage* the blood is poured out more quickly but not so much of it, as smaller vessels are ruptured, therefore the lucid interval is more likely to be absent, and the hemiplegia may only be a monoplegia, if that is not too Irish.

In *rupture of a sinus* the blood is poured out under less pressure, and the symptoms are correspondingly less severe. Blood is nearly always effused through the fractured skull under the scalp forming a puffy swelling.

In coma due to laceration of the brain, the lucid interval will probably be quite absent owing to the severe injury. Convulsive twitchings are probable.

As regards the diagnosis between cerebral hæmorrhage, embolism and thrombosis, the signs are pretty well known. The following points are taken from Taylor's Medicine:—

(1) The more severe and prolonged the coma, the greater the probability of hæmorrhage.

(2) Hemiplegia in which coma is absent or only slightly present, favours embolism.

(3) Age favours hæmorrhage or thrombosis. Youth excludes hæmorrhage unless there was an antecedent embolism.

(4) Heart lesion of course greatly favours embolism.

(5) A gradual onset favours thrombosis.

(6) Aphasia is slightly more frequent with embolism, as the left carotid is a more easy path for emboli.

Finally, we must remember that alcohol is the most frequent cause of coma or semi-coma as seen in casualty work.

Perhaps the next most frequent cause will be epilepsy, though most epileptics have recovered consciousness when brought up. Concussion is also very common. Apoplexy will come next, perhaps about one a month being admitted into this hospital.

Embolism, thrombosis and meningeal hæmorrhage are very much rarer causes of coma.

Uræmia and diabetes will seldom cause serious difficulty. With regard to the differential diagnosis between intra-cerebral and meningeal hæmorrhage, we must remember that though one case of the latter perhaps to four of apoplexy is admitted here. Yet in not one case out of ten will there be any difficulty in diagnosis, as most cases of meningeal hæmorrhage have very obvious lesions. So that if one is presented with a case in which he cannot diagnose between these two, he will think that the case has one-tenth chance of being meningeal. If it is meningeal, he has, say, one-third of a chance of saving the patient's life, so that he must fully consider whether he is prepared to trephine at once on one-thirtieth of a

chance of doing any good. But perhaps some would say that in a favourable case he would stand a much better chance of benefiting the patient.

In concluding this part of the subject, I would urge that the great danger is to pay too much attention to certain variable factors in diagnosis—such as the pupils. All signs and symptoms should be sought for in the order of their respective merits, and then an endeavour should be made to get a sort of bird's-eye view of the whole, before making a decision.

A FEW ANOMALOUS CASES.—

1. A man was admitted to John last May. He was walking along when he fell forward, vomited, and became unconscious, he was also said to have foamed at the mouth. He was said to have been in the sun all day and to have had some brandy. On admission he had a feeble pulse, and was comatose, but could be slightly roused by supra-orbital pressure. The face was flushed, extremities cold, corneal reflex absent, knee-jerks absent, no spasticity, and no paralysis, except that one side of his face was less wrinkled than the other. Pulse 97, temperature 95°, respiration 17. Pupils reacted to light. No squint. In a few hours he rapidly improved and went out quite well next morning, having confessed to a good deal of alcohol the day before. The diagnosis lay between heat-exhaustion and alcoholic coma.

2. A case of concussion followed by alcoholic coma somewhat simulating compression will be later alluded to. Some slight confusion may also be caused by syncopal attacks following concussion. For instance, the other day in the Front Surgery a woman was being dressed for a poker wound in the middle meningeal area. The wound went down to bone, but no fissure was felt. As she was being bandaged she got unconscious, or nearly so, but she had none of the ordinary signs of compression and the pulse was fast. It was an ordinary syncopal attack from which she soon recovered.

3. An alcoholic looking man was admitted under Mr. Jacobson recently. He had a cut on the left side of the back of his head which was stitched up, after which he was sent home. He then began to feel ill, and three days later was brought up and was admitted. On admission, in a semi comatose state, there was paralysis of the left arm and paresis of left leg. The pupils were equal and reacted normally. There was slight temporary conjugate deviation to the right. The wound seemed healthy. Temperature 102°, pulse 112, respiration, 44. Mr. Jacobson thought it might be septic meningitis, but decided to trephine on account of focal symptoms. Accordingly the right side was explored (*i.e.*, the side opposite the hemiplegia, and also in this case opposite the lesion). A thin dark clot was found under the dura, and partially incorporated with the pia. It was removed as thoroughly as possible, but the patient died of pneumonia. A suggested diagnosis in this case, chiefly on account of the hemiplegia associated with conjugate deviation, was left cerebral hæmorrhage, but the lucid interval would not fit in with that.

4. A few weeks ago a woman of 45 was admitted to Miriam in a comatose condition. She had been pushed over, and fell on the back of her head. She mumbled at times, and had automatic movements of her limbs, and could only be roused with great difficulty, and then only slightly. Her pulse was 64, respirations noisy and snoring rather than stertorous. There was no paralysis nor conjugate deviation. The urine reduced Fehling on boiling for some time. This reaction disappeared later. Perhaps the most generally accepted diagnosis was hysteria, or at least a functional nervous disorder, as she seemed to forget the movements at times. The temperature was irregular, rising and falling alternately. In a few days patient died, and at the autopsy a rupture of the corpus callosum was found with some blood in the ventricles. There was a little congestion of the posterior part of the brain, which might have been due to post-mortem changes.

5. In a case which was in the Front Surgery a few days ago, the patient had fallen down and knocked his head. He was unconscious for twenty minutes, and then recovered enough to walk up to the Hospital between two men. Soon after arrival at the Hospital he again got comatose suddenly. His face was congested, and he looked alcoholic. There was a slight bruise over one of his eyes. He could not be roused, and there was no corneal or light reflex. The pupils were contracted. The pulse was 80, and of moderate tension. The respirations for a short time were said to be stertorous, but soon were quiet. In spite of the complete absence of any one-sided symptoms, I thought for a short time that the case must be one of compression. But very shortly the pupils dilated and then contracted again, and the patient got less comatose and could be roused. Then we got a history of much drinking from his friends, which evidently took effect shortly after he had recovered from his concussion. In four hours he went home in a comparatively normal condition.

We now come to the last division of the subject, viz: TREATMENT.

We will first consider the treatment of a comatose case in which a diagnosis cannot be made. This is very simple:

(1) Wash out. It is difficult to see how this can do harm, and it may possibly save the patient's life. Use the soft tube, carefully: as otherwise, in a case of carbolic poisoning, for example, injury may be done.

(2) Open the bowels. Calomel gr. 5–10 may be used.

(3) Give no stimulants.

(4) Leave in a quiet place under observation.

We will now consider the *treatment of meningeal hæmorrhage* causing pressure. As noted above, this is rare, but as it is the only case in which the life of the patient may possibly be saved by treatment, it is by far the most important.

The diagnosis having been made the head should be completely shaved and purified.

No anæsthetic will generally be needed, and if it is, use chloroform, and as little as possible. The exploration should be made on the side opposite to the hemiplegia, wherever the bruise may be; or, if hemiplegia be absent, on the side of the dilated pupil.

If neither hemiplegia nor unequal pupils are present, the side of the contusion should first be explored, and then the other side if necessary.

A large flap should be turned down from the temporal fossa of the side chosen. This flap should include everything down to bone. If a fissure is found, the trephine pin should be placed on its edge where it crosses the middle meningeal artery.

If no fissure can be discovered, it is generally advised to trephine at a point one and a half inches behind the external angular process, and one and a half inches above the zygoma. As, however, the clot is usually, in the main, behind this point, and as the main trunk of the artery is not generally the one wounded, perhaps it would be just as well to trephine further back in the temporal fossa, say nearly above the ear. When there is very marked dilatation of the pupil of that side, the trephine may be applied somewhat lower down, as it is probable that the clot is extending towards the base.

Whilst using the trephine the depth of the circular groove cut should be continually gauged by a flat probe, and an attempt should be made to get through the whole circumference at the same time. Most probably when the disc of bone is removed the clot will present. The disc may be placed in warm normal saline or pushed under the scalp pro tem.

If the clot pulsates bleeding is still going on, and may be very hard to control, though it often stops spontaneously.

The clot should be gently removed with any sort of blunt scoop, an egg-spoon will serve, and very probably the hole will have to be enlarged in all directions with Hoffman's forceps to effect this. The cavity may then be *very gently* irrigated with 1 in 8000 sublimate solution.

If there is then no bleeding and the brain almost immediately expands, as may happen in a favourable case, the disc of bone may be put back and the wound sewn up with salmon gut without a drain.

If hæmorrhage occurs, and the bleeding point cannot be seen and secured, the hole in the bone will probably need enlarging downwards. The finger inserted between bone and dura may keep back the blood meanwhile. If the bleeding point can then be seen, it should be secured by under-running the dura, to which it will probably adhere, with a fully curved needle.

If in a groove in the bone, it may be got out of this groove with the help of a gouge, and so ligatured.

If it is in a canal this may be plugged with wax made aseptic by heat, or by Horsley's wax. If the bleeding cannot in this way be entirely stopped the older methods of *cold* (to the neck and over the wound), the sitting posture, or even the cautery may be tried.

If the brain does not expand there is no question of putting back the bone. A drainage tube should be put in and brought out at one angle of the wound externally.

If, in the above operation, no clot is found outside the dura, the latter should be carefully examined. If it bulge and appear bluish, it should be incised, and a subdural clot may be thus exposed. This should be washed away with saline if possible. Any oozing should then be stopped by light pressure with a hot sponge. The dural wound may then be closed, the bone replaced and the scalp sewn up. If the oozing cannot be quite stopped, a horsehair or other drain should be used.

If hæmorrhage occurs into the pia itself, an attempt may similarly be made to wash away the clot. Cheyne and Burghard then recommend putting in a piece of gold foil to prevent adhesions.

If no clot is found on exploring the anterior branch of the middle meningeal artery, the posterior branch may be explored at the intersection of a line from the exterior angular process to the external occipital protuberance, with one drawn directly upwards tangential to the mastoid process.

Progressive weakness, coma, and fever may continue owing to œdema after removal of the clot, or the brain may not expand. Therefore Percy Dean (in Treves' System of Surgery) recommends that if scraping away the clot does not relieve the symptoms, the dura should be incised, so as to let the brain bulge, and that if this bulging is considerable, the protuberant mass should be incised.

In cases of non-expansion of brain, stimulants are recommended, but not otherwise.

If hæmorrhage from the superior longitudinal sinus is suspected, trephine a little to one side of it. Hæmorrhage may be found outside the dura, but it is always well to incise the latter, as blood may be inside it as well. Occasionally a rent in the sinus may be repaired, but usually plugging will be sufficient.

As regards after-treatment in all "head" cases the patient should be kept on a milk diet, with no stimulants for some days. When the wound has healed the patient may be allowed to get up, and to take solid food.

Treatment of concussion.

1. Complete rest is the most important.

2. Open bowels by calomel or enemata.

3. Avoid stimulants, unless the collapse is extreme, then give strychnine.

4. If there is restlessness sedatives may be given when the patient will stand them. It is best to avoid morphia.

5. Cold to the head has never been proved to be of advantage.

6. Warmth and friction, etc., for the collapse.

7. Keep on liquid food till patient has a normal appearance, and has lost the dazed, frightened look sometimes seen. Solid food should not then produce any rise of pulse-rate or temperature. Then allow patient to get up. The pupils should also be normal, not dilated.

8. Bleeding may be of use when the reaction seems too vigorous.

9. The bladder may need attention.

Treatment of cerebral hæmorrhage.

1. Position.—On back with head raised. Bowles recommends the lateral position and this may be better when there are signs of much obstruction, as it allows free play to one lung at least and diminishes the liability to congestion of the bases.

2. Purgation. — Enemata will act most rapidly. Calomel and croton oil are most often used.

3. Venesection appears to be reasonable treatment when the hæmorrhage is still proceeding and the pulse tension is high. Fagge used it for cases of ingravescent apoplexy in the hope of stopping further hæmorrhage when the pulse was recovering from the shock.

Osler recommends it in all cases where the tension is high, and where it is pretty evident from the age of the patient that the symptoms are not due to embolism.

4. An icebag is probably useless. The application of warmth to all the limbs is more reasonable, as it would tend to withdraw some blood from the head and we have seen that the temperature is subnormal. In reaction, however, an icebag may allay pain.

5. No stimulants, and a milk diet.

6. See to the bladder.

7. The old practice of pressure on the carotid has lately been revived, on experimental grounds. I have no knowledge of its practical application.

8. The later treatment of the paralysed muscles need not be dealt with here.

Treatment of embolism.—In those cases in which embolism can be diagnosed with some approach to probability, there is no objection to giving stimulants (ether, ammonia, digitalis, etc.) should the pulse require them. Active purgation is not indicated, though the bowels should not be allowed to be confined. Of course venesection would be harmful. Treatment by rest, light diet, etc., should be carried out, as in hæmorrhage.

For *thrombosis* the same treatment will suffice.

Treatment of uræmic coma.

1. Free purgation, as by compound jalap powder or croton oil.

2. Diaphoresis, best by means of a hot-air bath. Pilocarpine may be used, but it is somewhat depressing, and these patients cannot afford to be depressed.

3. Venesection is often used, as also—

4. Saline infusion, or both combined. Theoretically this treatment ought to dilute the poison. Osler recommends the former if the patient is full-blooded.

5. Nitro-glycerine is also recommended by Osler. I have seen one case in which it undoubtedly did harm, and should prefer to give cardiac stimulants, such as digitalis and strophanthus.

6. As regards diuretics, water is the best, and should be freely given.

There is no objection to giving saline diuretics, such as the Imperial drink, or potassium citrate.

7. Lumbar puncture has been alluded to above.

Diabetic coma.

1. Open bowels. This may need croton oil.

2. Give large doses of alkalies. These may be given in much water or milk. ʒss. of sodium bicarbonate should be given six-hourly. If the patient is getting rapidly worse, a two per cent. solution may be infused into a vein. As much as four pints of this solution may be given. Under this treatment patients undoubtedly recover wonderfully for a time, but on a second or third application of the treatment they seem not to react so well, or not at all. The alkali should be pushed till the urine is neutral or alkaline.

3. Stimulants, oxygen, and saline infusions may avert the end for a short time.

Alcoholic coma.—Wash out and leave well alone. If the poisoning is very severe, friction and hot applications may be necessary, also alkaloid stimulants. For the convulsions, which very rarely occur, chloroform may be given.

Epileptic coma.—Leave well alone also. When the patient comes round he may be given a large dose of bromide to prevent a possible recurrence.

Opium poisoning.—1. Stomach pump.—Emetics may not act.

2. Stimulants.—Ammonia, coffee, atropine $\frac{1}{20}$ gr. hypodermically, ether, strychnine, electric stimulation, walking patient about, etc. This perambulation of the patient should never be carried so far as to exhaust him.

In severe cases the most valuable treatment is

3. Artificial respiration, which may be kept up till the heart fails. Faradization of the phrenic may also be tried.

4. Potassium permanganate is not recommended by Dixon Mann.

In *heat-exhaustion* use stimulants, and a hot bath if the temperature is very low.

In *sun-stroke* use the ice-pack to reduce the temperature. Use free venesection in the peculiarly rapid and fatal asphyxial form, and chloroform should be given if convulsions occur.

In conclusion, I thank you, gentlemen, for the patient hearing you have given to this paper, the length of which is only excused by the magnitude of the subject.

Papers by Guy's Men.

The Lumleian Lectures on Some Disorders of the Spleen. By Frederick Taylor, M.D., F.R.C.P. Lond.—*The Lancet*, May 28th.

A Case of Congenital Deficiency of both Upper Limbs. By H. Ashley Gaitskell, M.D. Cantab. Illustrated.—*Ibid.*

Sport.

Cricket.

GUY'S v. BLUEMANTLES.

Played at Tunbridge Wells on Wednesday, May 18th. The home side batted first on a good wicket and made 250, most of the team getting into double figures. Wyatt was the most successful bowler, taking five wickets for 64. We were left with two hours to bat, and in only making 148 for six, had none the best of the draw. Willan, Wyatt and Bookless played good innings. Scores:—

GUY'S.

J. S. Bookless, c Braybrooke, b Gwynn	23
H. Simms, c Leney, b Williams	2
R. Willan, b Leney	49
F. A. Husbands, b Williams	16
H. W. Wyatt, c Williams, b Gwynn	21
H. Archer, b Leney	0
O. G. Iliffe, not out	15
B. T. Verver, not out	13
Extras	9
Total (6 wickets)	148

P. C. Lichfield, S. A. Piper, G. Russell, did not bat.

BLUEMANTLES.

S. S. Williams, c Lichfield, b Russell	20
W. L. Gwynn, c Willan, b Wyatt	14
Capt. Barrow, b Wyatt	13
J. H. Kelsey, b Willan	26
F. B. Leney, lbw, b Wyatt	37
Major Spens, st Iliffe, b Verver	54
P. J. Meads, b Willan	7
T. N. Mitchell, not out	45
E. C. Nicholson, lbw, b Wyatt	4
L. Andrews, b Wyatt	0
A. P. Braybrooke, not out	11
Extras	19
Total	250*

* Innings declared closed.

GUY'S v. WANDERERS.

Played at Honor Oak Park, on Saturday, May 21st. Wyatt won the toss and put the visitors in. We succeeded in getting rid of them for 154, owing to some good bowling by Wyatt and Davies. Rain then stopped play for a considerable time, which robbed us of a victory, as we got within 50 runs of their total with only five wickets down. Tolhurst played an excellent innings of 43, being caught off the last ball sent down. Scores:—

WANDERERS.

S. Coleman, c Bookless, b Wyatt	29
D. S. A. Jephson, c Husbands, b Davies	0
A. E. Damian, b Wyatt	22
R. B. Brooks, c Tolhurst, b Davies	1
K. E. M. Barker, c Carter, b Davies	0
W. T. Grayburn, c Bookless, b Davies	30
T. H. Darke, b Wyatt	24
L. S. Wells, not out	30
J. D. Gillespie, c Wyatt, b Bookless	1
M. R. Smith, b Wyatt	1
H. F. Waller, c & b Bookless	1
Extras	15
Total	154

GUY'S.

J. Bookless, st Brooks, b Jephson	12
A. M. Tolhurst, c Gillespie, b Barker	43
R. Willan, c Jephson, b Barker	1
F. Husbands, b Barker	2
H. D. Wyatt, c Brooks, b Barker	3
H. Archer, not out	24
Extras	18
Total (5 wickets)	103

L. G. Davies, A. Leeming, H. Simms, H. H. Carter, and O. G. Iliffe did not bat.

GUY'S v. NORBURY.

Played at Norbury on Whit Monday. The home side went in first and made 168, of which 50 were put on for the last wicket. We were left with two hours and a quarter, and just succeeded in getting the runs three minutes before time. Wyatt and Bookless made a splendid start, putting up 106 before being parted, but nine more wickets fell before the runs were hit off, most of our men getting out in trying to hit. Scores:—

NORBURY.

P. F. Wilson, c Bookless, b Davies	29
M. C. Dahl, c Simms, b Wyatt	3
C. B. Wood, not out	79
H. K. Whiting, b Davies	4
N. Hammill, c Bartlett, b Davies	4
W. E. Hobbs, b Willan	8
E. Langton, b Willan	0
H. C. Plummer, b Davies	0
J. L. Jordan, c Wyatt, b Bartlett	11
J. C. Cunningham, b Willan	1
R. Langton, c Leeming, b Bartlett	0
F. C. Dight, c Bookless, b Edey	25
Extras	4
Total	168

GUY'S.

H. D. Wyatt, c Plummer, b Wilson	51
J. S. Bookless, b Jordan	64
R. Willan, b Jordan	7
A. M. Tolhurst, st Hammill, b Jordan	4
A. Leeming, b Jordan	5
H. Archer, c Hobbs, b Jordan	16
H. Simms, b Whiting	6
J. L. Atkinson, b Whiting	1
J. J. MacAldin, b Jordan	0
L. G. Davies, b Jordan	0
G. N. Bartlett, not out	0
Extras	17
Total (10 wickets)	171

T. H. Edey, did not bat.

GUY'S v. SURREY CLUB AND GROUND.

Played at Honor Oak Park on Wednesday, May 25th. The visitors won the toss and took first innings; they were dismissed for 144, Goatley playing a good innings of 42.

Our batting broke down against the bowling of Rudd and Rushby, and we were all out in a little over an hour for 65. Scores:—

SURREY C. & G.

J. H. Bryant, c Bookless, b Piper	7
Goatley, b Willan	42
Tring, c & b Piper	10
W. T. Graburn, b Piper	6
Stedman, b Piper	18
Cotton, lbw Willan	21
Capt. Kirkback, b Davis	6
E. H. T. Harper, c sub b Wyatt	1
F. Gandy, c Bookless, b Willan	0
Rushby, st Wells, b Willan	14
Jackson, not out	8
Extras	11
Total	144

GUY'S.

J. S. Bookless, lbw Rushby	17
H. D. Wyatt, c Harper, b Jackson	25
R. Willan, c Harper, b Jackson	1
H. A. Newman, b Rushby	12
H. Archer, c Tring, b Rushby	0
A. Leeming, run out	0
H. Sims, lbw b Jackson	3
L. G. Davies, c & b Jackson	0
R. W. Allen, not out	0
S. M. Wells, b Rushby	8
S. G. Piper, b Rushby	0
Total	65

GUY'S v. WESTMINSTER.

This match, in the first round of the Inter-Hospital Cup, was played at Honor Oak Park, on Friday, May 27th. Guy's won by 261 runs, Archer, top scorer, making 91, his hitting to leg being especially good. All but one of the team got into double figures. Westminster made a poor show against the bowling of Davies and Wyatt, being all out for 81. Davies took 6 wickets for 27, and Wyatt 3 for 40. Scores:—

GUY'S.

H. Barber, b Wood	11
H. D. Wyatt, c Hayward, b Farrant	26
R. Willan, c Barker, b Austin	42
J. S. Bookless, c & b Bryson	17
F. A. Husbands, c Farrant, b Wood	44
A. M. Tolhurst, c Austin, b Barber	17
H. Archer, lbw Dawson-Smith	91
H. Simms, c Carr, b Austin	11
L. G. Davies, b Austin	4
S. M. Wells, not out	39
S. A. Piper, b Wood	20
Extras	20
Total	342

WESTMINSTER.

R. S. Barker, c Wyatt, b Davies	19
C. Hallett, b Davies	15
T. S. Wood, run out	0
P. Farrant, b Davies	5
P. G. James, by Wyatt	0
A. C. Bryson, c Wells, b Wyatt	18
A. W. Hayward, b Davies	0
G. L. Johnston, b Davies	6
C. Austin, st Wells, b Wyatt	4
Dawson-Smith, c Wyatt b Davies	0
G. Carr, not out	0
Extras	14
Total	

GUY'S 2ND XI. v. THESPIDS.

This match was played on a very wet wicket at Shepherd's Bush on May 27th. Winning the toss we put our opponents in, and they compiled 107. We only made 60, finishing the game in rain and a very bad light. Scores:—

THESPIDS.

H. Mills, b Russell	0
S. Mills, b Russell	14
D. V. Hussard, b Russell	3
R. Denbigh, c Townrow, b Taylor	27
B. Egerton, b Strange	11
Conway Tearle, c Norton, b Moyle	2

H. Nye-Chart, not out	31
C. La Trobe, b Strange	0
F. Stayton, c & b Bartlett	7
R. Darvin, b Bartlett	4
S. Brett, b Bartlett	0
Extras	3
Total	102

GUY'S 2ND XI.

E. Whelon, c Hussard, b Denbigh	19
E. W. Strange, b Denbigh	0
E. L. Norton, c Egerton, b Denbigh	10
H. G. Gibson, b Denbigh	15
J. L. Atkinson, c La Trobe, b Tearle	1
H. H. Moyle, b Tearle	0
A. D. Vernon-Taylor, b Egerton	2
Sub, c Tearle, b Hussard	4
G. N. Bartlett, not out	1
G. Russell, b Hussard	0
V. Townrow, b Egerton	2
Extras	6
Total	60

Guy's Hospital Lawn Tennis Club.

On Saturday, May 7th, we played Surbiton "A" at Honor Oak Park, it had been a wet morning and so one of their pairs did not put in an appearance. An unsatisfactory match ended at two all.

Palmer and Zorab beat Walker and Ames, 6–2, 6–2; lost to Hopkins and Perkin, 2–6, 6–1, 4–6; Orpen and Greene lost to Walker and Ames, 6–4, 4–6, 4–6; beat Hopkins and Perkin, 6–1, 6–4.

Wednesday, May 18th, Harold beat us by five events to four, the first pair winning all their events, but the other pairs could only muster one between them.

Palmer and Zorab beat Thomson and Ransford, 8–6, 6–3; beat Greene and Wheeler, 6–3, 8–6; beat Gunn and Eccles, 6–2, 6–2; Orpen and Morris lost to Thomson and Ransford, 7–5, 3–6, 2–6; beat Greene and Wheeler, 6–3, 6–3; lost to Greene and Eccles, 4–6, 0–6; Greene and Adams lost to Thomson and Ransford, 1–6, 2–6; lost to Greene and Wheeler, 2–6, 1–6; lost to Gunn and Eccles, 2-6, 2–6.

Wednesday, May 25th, we lost to Sidcup by six to two. Palmer and Zorab lost to Beater and Longstaff, 4–6, 2–6; beat Solomon and Thompson, 6–2, 5–2 (retired); beat Young and H. Thompson, 6–4, 6–2; Orpen and Morris lost to Beater and Longstaff, 4–6, 1–6; lost to Solomon and F. Thompson, 6–2, 6–8, 2–6; Greene and Barker lost to Beater and Longstaff, 0–6, 2–6; lost to Solomon and F. Thompson, 3–6, 2–6; lost to Young and H. Thompson, 3–6, 1–6.

Saturday, May 28th, Wanstead beat us by six to three. F. Palmer and Zorab beat Ramsay and Thirgood, 6–3, 6–3; lost to Takum and Blewit, 6–3, 7–9, 3–6; beat Dobson and Eustace, 6–0, 6–1; Orpen and Morris lost to Ramsay and Thirgood, 1–6, 0–6; lost to Takum and Blewit, 3–6, 5–7; beat Dobson and Eustace, 6–4, 4–6, 6–3; A. Palmer and Barker lost to Ramsay and Thirgood, 0–6, 3–6; lost to Takum and Blewit, 4–6, 2–6; lost to Dobson and Eustace, 1–6, 3–6.

Change of Address.

L. U. Ransford, L.D.S. from Guy's Hospital, to Peakville, Anerley Hill, Upper Norwood, S.E.

C. Knox Shaw Esq., from 19, Upper Wimpole Street, to 19, Bentinck Street, London, W.

J. E. Spiller, L.D.S., from Ecole Dentaire, Paris, to Newton Terrace, 128, Worple Road, Wimbledon, S.W.

Dr. A. H. E. Wall, from Guy's Hospital, to Wanganui, N.Z.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Pass List.

University of Cambridge, May, 1904.

DEGREE OF BACHELOR OF SURGERY.

W. M. Mollison.

University of London, May, 1904.

M.B. EXAMINATION FOR INTERNAL AND EXTERNAL STUDENTS.

FIRST DIVISION.—H. D. Smart.

SECOND DIVISION.—H. H. Carter, J. H. Clatworthy, P. W. Hamond, C. E. Iredell, H. S. Jones, M. G. Louisson, H. C. C. Mann, B. Moiser, E. C. Myott, P. A. Peall, C. B. Penny, G. W. Russell.

University of Durham, April, 1904.

DEGREE OF DOCTOR IN MEDICINE.

M. C. Wetherell.

DEGREE OF DOCTOR IN MEDICINE.
(For Practitioners of Fifteen Years' Standing).

A. Hooper.

DEGREES OF BACHELOR IN MEDICINE AND BACHELOR IN SURGERY.

O. B. Travers.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane* :—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

G.E.H., RAMSGATE.—The tumour has probably originated in an outlying lobule of breast tissue. It presents the characteristic appearances of chronic mastitis, and there is nothing obviously malignant to be seen.

S.W., MIDDLESBOROUGH.—This sputum contains a considerable number of tubercle bacilli, and many of them are arranged in clumps.

T.R.A., CHADWELL HEATH.—A fair number of tubercle bacilli were found to be present in this specimen of sputum.

G.E.H., RAMSGATE.—Reaction acid, sp. gr. 1015, albumen a trace only, sugar absent, blood vide infra. Microscopical examination of the centrifugalised deposit: The deposit is moderate in amount, and consists of mucin and a small quantity of pus, together with some vesical squames and numerous bacteria associated with decomposition. Red blood discs are very scarce, and no tube casts are noted. Tubercle bacilli cannot be found. The condition seems most suggestive of vesical catarrh, but it is possible that the pus may be of prostatic origin.

PATHOLOGIST.

Appointments.

Civil.

BROWN, A. T. FRANKLYN, M.D. Durham, M.R.C.S. Eng., has been appointed Certifying Factory Surgeon for the Chatham District, Kent.

HAMOND, P. W., M.B. Lond., M.R.C.S., L.R.C.P., has been appointed Resident Assistant Medical Officer at the Lewisham Union Infirmary.

MORICE, C. G. F., M.D., F.R.C.S., has been appointed Public Vaccinator for the Grey District, No. 2.

REDPATH, J. S., L.D.S., has been appointed a member of the Medical and Pharmacy Board of the Orange River Colony.

WALL, A. H. E., M.B. Lond., M.R.C.S., L.R.C.P., has been appointed Public Vaccinator for the Wanganui District, N.Z.

Naval and Military.

Fleet Surgeon JOHN DOWSON, R.N., is placed on the Retired List, May 14th.

Staff Surgeon WALTER J. BEARBLOCK, R.N., has been appointed to the *Northampton*.

Lieutenant S. A. RUZZAK, I.M.S., is promoted to be Captain.

Births.

HARRISON.—On May 25th, at 8, Waterloo Place, Brighton, the wife of William W. Harrison, L.R.C.P. Eng., M.R.C.S., of a son.

TURNER.—On May 20th, at Oak House, New North Road, Huddersfield, the wife of F. Douglas Turner, M.B. Lond., of a son.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 421.] JUNE 18, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	245–247
A Case of Cerebellar Tumour	248–252
Notes from Skin Outers	252
With Dr. Shaw at Medical Out-patients ...	253
In Lighter Vein	254–255
A New Method of Administration of Chloroform	255–256
Guy's Hospital Dental Society	256
Nursing News	256
Junior Guyite Club	256
Correspondence	257
Another Pointless Fable	258
From the Gazette's Special Pathologist ...	258
Reviews	258–259
A Dining Room Dialogue	259–261
Sport	261–262

Passim.

THE date fixed for the Annual Prize-Giving and Garden Party is Wednesday, July 6th, when the medals and prizes will be distributed by The Right Honourable The Viscount Goschen. There is no ceremony of especial interest to be gone through on this occasion as there has been for the past few years, but no doubt the gathering will be none the less representative on that account. It only remains to be hoped that the weather will be as excellent this year as it was last.

IT is to be hoped that at least some part of the new Actino-Therapeutic Department will be ready against Prize Day. That the whole of it will be completed is perhaps too much to expect, for the scheme is an extensive one, and up to the present the workmen do not seem to have made very much headway. A great feature of the department will be the system of cubicles, which will give some degree of privacy to the patients—an impossibility in the present rooms for the obvious reason that space does not allow of it. Special rooms have already been set aside for the static machine and for the hot-air bath, but up to the present these compartments are entirely innocent of furniture of any kind. When the department is in full working order it is to be hoped that there will be opportunities afforded the men to get some practical knowledge, however slight, of the fundamental principles of electrical treatment and of the various forms of light cure, which latter is at present an entirely closed book to the majority, and certainly it would be nothing short of cruelty to animals were the present electrical department to be the happy hunting-ground of the earnest seeker after knowledge. No doubt the top landing of the surgical block will in any case be equal to the task of facing the enquiring eyes of the layman on Prize Day, for probably, were the new department to be completed, the various showmen would be vague to a degree in their explanations, and if an unfinished condition of things necessitates an accentuation of that vagueness—well, the lay mind will probably be all the more impressed!

THE appointment of Obstetric Dresser, hitherto of three months' duration, is in future to be held for two months only, the first month of which is to be occupied in clerking and the second in dressing. This will be, on the whole, a welcome innovation, for to most men nearing the end of their course the months are valuable. For the more junior men there are rumours of a still more welcome change in the near future, namely, the cutting down of the number

of anatomy lectures during the winter session from four to three a week. The nine o'clock lecture is a thorn in the flesh of both lecturers and students, and nobody will regret it, should the Staff decide to abate the agony. The majority of us will bewail the fact that we were unfortunately born before our time, and will remember with a twinge of regret the many cramped hours spent in the old anatomy theatre with an ill-digesting breakfast, which hours we might have been spared had we entered this best-of-all-possible hospitals a little later. An important point for the young anatomist to discover yet remains, namely, whether the same number of attendances as heretofore are still required of him.

A SHORT time ago the rumour got about, and was endorsed (to put it courteously) by a well-known morning paper, that Dr. Boycott, the Gordon Lecturer, whose researches in Ankylostomiasis are so well known to the medical world, was himself suffering from this distressing malady, and he received many letters of condolence from his friends and admirers on the strength of this announcement in the paper. We are in a position to state that there is no truth in this report, and that, far from being a martyr to science, Dr. Boycott is in perfect health. We are inclined to regret the opportunity he has missed of being interviewed by some energetic reporter, who could have drawn a harrowing picture of "how some scientists live." The literary world is the poorer for Dr. Boycott's scrupulous honesty, but the incident shows what might be attempted by a second De Rougemont.

THE recent judgment of Mr. A. P. Longstaffe, barrister-at-law, in the case for arbitration between Dr. Eyre and the Scottish Life and Fidelity Insurance Company, should constitute a very serious warning to all medical men contemplating insurance, and especially to pathologists and bacteriologists, who may at any time find themselves in a similar situation owing to an insufficient enquiry into the terms of an accident policy. In this case Dr. Eyre imagined himself insured against all forms of septicæmia, but was refused compensation by the above Company for his having contracted Malta fever from accidental laboratory infection. The Company's principal objection was apparently based on the fact that Malta fever was not included in the classification of septicæmia drawn up by the Royal College of Physicians in 1892, which classification was considered to be final under the terms of their policy. The fact that Malta fever has since that date been shown to be a septicæmia did not alter the legal aspect of the question, and Dr. Eyre accordingly lost his case. It will thus be seen that the importance of enquiring fully into the details of such insurance policies cannot be over-estimated, and extreme caution should be exercised before taking out the same.

WE should like to call special attention to the proposed testimonial to Dr. Eyre, which it is intended shall defray the cost of the arbitration, amounting to some £140. Many old Guy's men will have received a letter from Dr. Bryant on this subject, but in case there should be any who might like to subscribe and who have not received any communication, we refer them to the preliminary list opened in another column.

THE immortal Leno, to whom apparently "all things are possible," has said "not the ordinary fire-brigade"—may he forgive us if we misquote, that, at any rate, is the gist of his remarks. We are to be favoured at Guy's with another extraordinary fire-brigade, perhaps not so business-like as that of Mr. Leno, but still every bit as picturesque. The hospital workmen have found a vent for their surplus energies, and have formed a salvage corps! Their uniforms are magnificent, and we are told that no expense has been spared. Some day in the near future we are to have a parade-day, and then, in all the panoply of the fireman, with a little extra touch of colour possibly, as each man shall think fit, will the wily workman scale the ladder and rescue—who knows?—perhaps the shrieking wardmaid! Henceforth let all gratuitous firemongers beware—he who smokes where he "didn't oughter" is liable to a severe blow from a salvage axe or to a drenching from the hose of these indomitable fellows. Such a possibility "gives one furiously to think!"

All will heartily congratulate the Cricket team on their victory over Charing Cross in the second round of the Inter-Hospital Cup Tie. We were fortunate in winning the toss, and batted first on a good run-getting wicket, both Willan and Tolhurst scoring centuries and playing excellent cricket. In the holidays we were led to contemplate the approaching season with the resignation born of despair, but now, with half the term behind us, we can review the past with a certain chastened satisfaction. The team does not exhibit that curious slackness which has characterised our sides for the past few years, and, with increasing keenness assured, there is reasonable ground for hoping for future successes in the Cup Ties. Disquieting stories are on foot as to the prowess and invincibility of the London Hospital's eleven, and, mindful of the late lamented Rugby Cup and its captors, we are inclined to believe these rumours; but should we have to meet our old enemies, at least our 1st XI. will see to it that it shall not be a walk-over.

The Past v. Present Cricket Match will be played at Honor Oak Park, on Saturday, June 25th. Will all those wishing to play for the Past team kindly communicate with Mr. H. M. Langdale, Guy's Hospital? This is not giving men very long notice, but it is hoped that a sufficient number of names will be forthcoming.

In another column will be found a letter from Mrs. Toogood-Hill, the Hospital artist, who is leaving Guy's after a ten years' tenure of office. Mrs. Hill has done valuable work for the Hospital, and has ably filled a somewhat unique post. She carries away with her the good wishes of her friends at Guy's.

Since the departure of Mr. Betts, whose pigeon fund many will remember was replenished in exciting and wonderful ways, not without a certain amount of risk sometimes to the kindly old gentleman, the pigeons have not been left desolate, but have been cared for by a certain lady whose name even is unknown to us. There is something peculiarily melancholy in the fact that charity is sometimes wasted on undeserving subjects.

Faithful to a previous promise, we have, in the present number, opened a Kipling Prize Competition. There were some who objected to the idea of a money prize in connectiou with so excellent a periodical, a few there were who even declared that we had lowered the Gazette to the level of any threepenny daily paper. We would remind these gentlemen that the recent appearance in our columns of the Library Committee's Competition has vindicated our action in a most respectable and effective manner, and with regard to threepenny daily papers we would rather leave them to their readers amongst that "aristocracy of thought" (*vide* advt.) to which, we thank Heaven, we do not belong.

We should like to draw the attention of all those recently qualified men who are anxious to join one of the services, to the many advantages offered by the Army Medical. The chief points of recommendation are these. In the first place, the entrance examination (as indeed all future service examinations) is of an entirely practical nature, requiring no prolonged book cramming, but as much general clinical work as possible. Commentaries and aural examinations take the place of the customary written papers. The present facilities for holding resident house appointments after entering and before actually joining the service are of the greatest value. A lieutenant on probation may thus be "seconded" for any period not exceeding one year, during which time he retains his original place on the Army List, and coincidentally enjoys all the advantages of an hospital appointment Increased rates of pay with additional allowances for hospital charge, specialist duty, and foreign service; the possibilities afforded for advancement and original research; the rapidity of promotion and the benefits of a substantial pension or gratuity on retirement, are all points which must highly commend the service.

A Case of Cerebellar Tumour.

CLINICAL LECTURE By Dr. SHAW.

May 4th, 1904.

Gentlemen,—As this is the first lecture on clinical medicine which has been given at the school since a somewhat important change has been made in the arrangements for clinical study, I though perhaps it would be well if I made some slight reference to it. We are so much in the habit at Guy's of carrying on traditions—and they are always good traditions which we carry on—that perhaps we are not always alive to our occasional duty in creating traditions; and unless the proper tradition is created with reference to this change in the teaching of clinical medicine, I am afraid that the expected advantages will not result. You know to what I am referring. In the past it was the custom of a student to commence ward work by holding a surgical ward clerkship; and after three months he either passed on to become an assistant-surgeon's dresser, or a medical ward clerk, as choice or fate determined. In the future every student, after finishing his three months as surgical ward clerk, will commence his medical ward clerkship; and after three months in the medical wards he will pass back into the surgical wards for three months as an assistant-surgeon's dresser; and he will then return to the medical wards to complete his medical ward clerkship. If this results merely in your dividing the work of your medical ward clerkships into two periods of three months, I am afraid it will not have a very beneficial effect. What is hoped by the authorities of the school is that it will extend your first period of study of clinical medicine from a six months' course into a nine months' course. Having once been introduced to the medical wards, medical out-patient department, and the post-mortem room, it is hoped that the cases with which you will have been connected in the first three months will retain your interest in the second three months, and thus the tradition will arise that during the whole of these nine months you will be studying medicine and surgery together. This change has been made partly because the Examining Boards are throwing upon you a very considerable increase in the amount of laboratory work and other duties which take you from the wards; and unless the earliest opportunity is given you of commencing what should be an almost constant attendance in the medical wards you may cease to maintain the tradition of being good practical men, a tradition which has always been handed on by those educated at Guy's Hospital.

Now I must come to the business of the day, and that is, to introduce to your notice a case of cerebellar tumour. Some of you, on Friday afternoon last, saw, in my out-patients, a little blind boy, who was sent up by Dr. Featherstone, of Aldershot, for an opinion on his condition. Dr. Featherstone is one of those old Guy's men who, remembering what interesting cases he saw when he was here, is in the habit of sending up to the wards or the out-patient department interesting cases which he comes across in private practice. I hope many of you when you get into private practice will remember this gentle hint. I should have been glad if I could have presented the boy to you, but I have not been able to get him here to-day. However, I hope he will be an in-patient shortly, so that he may be examined more fully by those of you who are sufficiently interested.

He was a nice little boy of about five years of age, distinctly chubby, and was carried in by his mother, who said that he had gone quite blind in the last few months, and that he used to have very bad attacks of headache and sickness, but they had lately become much better. She further stated that he was getting fat because he ate such a lot and he could not run about. He was quite blind, he could not stand on his legs, and was constantly falling down. Thus briefly did the mother describe the boy's illness. We looked at his legs and found that they were well nourished and appeared fairly strong. We found his knee-jerks were absent. I then put him on the ground and let him wander about amongst us. Not only could he not see, but it was obvious that he was very defective in the powers of locomotion. When he stood still his feet were very wide apart. When they were gradually pushed nearer together he invariably separated them, for when they were closer than five of six inches from each other he became very unsteady. On drawing attention to the large size of his head, the mother said that it had been growing very much lately and had become of a curious shape. I then examined his eyes with the ophthalmoscope, and found an explanation of his blindness in double optic neuritis. At that point, perhaps rather rashly, I ventured to express the opinion that he was suffering from a cerebellar tumour. Had he been an in-patient, and had I had more

time, I should have gone into the case more fully before making a diagnosis. But there had been six symptoms already brought out which, taken together, will certainly generally justify a provisional diagnosis of cerebellar tumour. Taken in the order in which we found them the six symptoms were—(1) blindness, (2) headache, (3) vomiting, (4) ataxia, (5) absent knee-jerks, (6) enlarged head. I have divided these symptoms into two groups. (A) Blindness, headache, vomiting; (B) ataxia, absent knee-jerks, enlarged head. It is desirable to group the symptoms in this way whenever you are dealing with a supposed case of intracranial tumour. Some of the symptoms, those in group A, are entirely independent of the situation of the tumour; they occur whether the tumour is in the pons, the pituitary body, the frontal lobe or anywhere else in the cranium. On the other hand, the symptoms in group B are what are called localising symptoms, their presence ought to enable you to express an opinion as to the probable situation of the tumour. There is another group of symptoms sometimes present in intracranial tumours not illustrated here at all, upon which you might base an opinion as to the nature of the tumour. In the exceedingly lucid manner in which Sir William Gowers deals with nervous diseases, he makes it very easy for the student to appreciate these three groups of symptoms, and I do not think I can do better than follow his method. He says that these groups of symptoms answer three definite questions. Group 1 answers the question, Is there a tumour? Group 2 answers the question, Where is the tumour? Group 3 answers the question, What is the tumour? So far as the case before us to-day is concerned we have dealt with only two questions—Is there a tumour? and Where is the tumour? Our investigation at Out-patients showed no symptoms helping us to answer the third question.

I propose to take these six symptoms which I was able to demonstrate in this small boy the other day, and to consider some of their bearings upon the diagnosis. Take first the very common symptom, headache. You will at once observe that headache in itself cannot possibly be an indication, or at least a pathognomonic sign of cerebral tumour. It is such a very widespread symptom, it enters into nearly every disease, and is a symptom which probably every one of our patients has suffered from at one time or another. So that headache can only be of value in diagnosis when taken in relation to other symptoms. If it be associated with vomiting and optic neuritis there is generally little doubt as to the existence of an intracranial lesion. Sometimes the mere intensity of the headache may be considered an indication of the presence of an intracranial lesion. It is stated that a headache which keeps the patient awake at night or wakes him up, is likely to be dependent on an intracranial lesion; but as a matter of fact I think one must admit that neither the character, the position, nor the intensity of the headache will give you any certain indication of the existence of a tumour. Its only diagnostic value is in association with other symptoms. The chief cause of headache in cerebral tumour is increased intracranial pressure, and its severity therefore depends a good deal upon the rapidity with which growth takes place. You will remember the mother told us this boy's headache had been severe but that it had practically ceased. This probably indicates that the growth of the tumour had been temporarily arrested. Some physicians have thought that while pain does not give any indication of either the existence or situation of a tumour, yet localised tenderness is of some value as an indication of position On the whole, one must say that the existence of headache gives no answer to the question, Where is the tumour? nor to the question, What is the tumour? though its association with other symptoms is of great value in helping us to answer the question, Is there a tumour?

Vomiting is another of the symptoms which help to answer the question, Is there a tumour? It is of course of no value at all except in relation to other symptoms, for I could occupy the whole of this hour in merely enumerating the various possible conditions which might give rise to vomiting. There is one point which has led some people to think that vomiting might possibly help to answer the question, Where is the tumour? It is stated that owing to the fact that the cerebellum has to deal in some way with the function of equilibration, a tumour in the cerebellum would make the patient more sick than one in any other part of the brain. The evidence in favour of this is very slight, and the statement is perhaps based upon the analogy of sea sickness. And should not this analogy suggest to us that the urgency of the vomiting in cerebral tumour would depend as much on the personal equation as on the site of the lesion?

The third symptom which helps us to answer the question, Is there a tumour? is blindness. After I had stated my view as to the nature of this case, one of my out-patient class on Friday asked me why a lesion in the cerebellum should

cause a patient to be blind. It showed that he remembered, at least negatively, the functions of the cerebellum but that he had not appreciated to which group of symptoms blindness belonged. It is true that in rare cases the situation of the lesion might afford an explanation of the blindness; for instance, a tumour might destroy the optic chiasma; in that case the patient would be blind because sight could no longer be conveyed to the brain. If a tumour were in the occipital lobe it is possible the patient might have hemianopia, and if he had a symmetrical tumour in each occipital lobe he might possibly be blind owing to a central cause. But for one case of blindness due to a tumour in the portion of the brain which presides over sight, there are hundreds due to a much more obvious cause, namely, to inflammation, and subsequent atrophy, of the optic nerve. It was clear, on looking at this boy's eyes, why he was blind; the tumour had set up double optic neuritis, and that neuritis had passed on to atrophy. The patient was blind, not because the brain was unable to receive the impressions, but because the optic nerve was unable to convey them. The optic neuritis, I had to point out to the enquirer, merely tells us there is a tumour; it does not indicate where it is. Why should a tumour situated in any part of the brain lead to optic neuritis? It is a difficult question to answer. The obvious answer, and one which is generally admitted to explain most cases, is that the intracranial tumour, by causing increased pressure, produces an engorgement of the vessels of the optic disc, and thus sets up inflammation. That is not a quite sufficient explanation, because in many cases where the tumour is small the amount of increased intracranial pressure must be very slight and yet there may be very extreme optic neuritis. In other cases, with very large tumours, optic neuritis may be absent. Nor will the question of the rapidity of the growth of the tumour explain these apparent contradictions. It is, therefore, assumed by some that an inflammatory process is conveyed along the sheath of the optic nerve as the result of the intracranial tumour. There seems to be an objection to this, because cerebral abscess much more rarely produces optic neuritis than does cerebral tumour, yet if neuritis were due to extending inflammation as ordinarily understood one would expect it to be commoner with abscess than with tumour. Whatever the explanation is, the frequency of optic neuritis in cerebral tumour is very striking. Now you should remember that patients with marked optic neuritis may have almost perfect vision. If you do not remember this you are likely to assume that a patient coming with a bad headache and telling you she can see well, has not got optic neuritis. You can never be confident that optic neuritis is absent, except by making an examination with the ophthalmoscope. So that when a patient becomes blind it is clear that something more than optic neuritis has happened, as in the case of the boy before us. There is optic atrophy. This boy's discs were white, the vessels were small, but the discs were still somewhat enlarged. It was indeed a form of atrophy which is called secondary atrophy. Sometimes patients will have an atrophied optic nerve without having had any preceding neuritis, a condition spoken of as primary atrophy. It is a rare condition, occurring chiefly in locomotor ataxy. This boy's atrophy, the much more common kind, is that which results from acute inflammation. It is to be recognised partly by the fact that whereas in primary atrophy the disc is perfectly uniformly contracted, in cases in which inflammation has preceded the atrophy the margin of the disc is likely to be irregular.

These three symptoms, headache, vomiting and optic neuritis, incline us to give an affirmative answer to the question, Is there a tumour? We noted the absence of two other symptoms rather common in cerebral tumour, which combined with these three would have still further strengthened the opinion that a tumour existed. Vertigo is one of them, convulsions is another. I cannot hear that this boy has suffered much from vertigo, but small children are rarely able to express their sensation of vertigo, and in its slighter form it probably is not to be distinguished from a feeling of sickness. The boy had had no convulsions, for that is a symptom which would surely have been observed.

We now come to the symptoms which help us to answer the question, Where is the tumour? And the two which led me to believe that the tumour was probably in the cerebellum were the existence of an ataxic gait and the absence of the knee-jerk. You are familiar, from your physiology books, with the remarkable behaviour of animals whose cerebella have been removed; how they are unable to remain in certain positions; and how they are likely to fall and to rotate in various directions, symptoms which make it clear that the cerebellum is the seat of some important function connected with the maintenance of equilibrium. We should therefore expect in man that anything which removes or compresses portions of the cerebellum would interfere with equilibration.

Evidences of such an interference we observed in this small boy. There are not many other conditions in which an inability to maintain one's equilibrium is produced by disease. The common functional one due to alcoholic poisoning is familiar to you all and generally easily recognisable. Always make sure that a supposed inco-ordination of movements of the legs is not really due to loss of power. When I was registrar I well remember going to see a patient, and as I was approaching the bed I saw two ward clerks investigating the case. Never wishing to interfere with enthusiasm of that sort, I lay low. They took the man out of bed, held him up by the side of it, put his feet together, and said, "Now shut your eyes." He did so, and they let him go, and he fell down. A note was duly made that the patient was unable to stand with his eyes shut and his feet together. He had been unable to stand for many years under any circumstances. We recognised in this little boy that he was able to stand with his feet wide apart and to use his muscles with considerable force, but he was not able to properly perform the co-ordinated movements which enabled him to maintain his equilibrium properly. It is stated in the text-books that you can distinguish between the ataxic gait of cerebellar tumour and that of locomotor ataxy, but I do not advise you to lay very much stress on the supposed differences. I have found it very difficult to express any opinion, from the mere gait, as to which disease is present. I believe it is said that in the ataxic gait of tabes dorsalis the feet are raised higher and brought down with more force than when the ataxia is cerebellar in origin. But I think we must say that, having found your patient to be ataxic, you must decide whether the lesion is in the cerebellum or in the cord by the associated conditions.

Some physicians have felt a difficulty in regarding ataxy as a symptom of cerebellar disease, because many cases of cerebellar tumour have been found in which the patient had not shown an abnormal gait, and various views have been advanced to explain why this is. It is said that the presence of ataxia must depend on some particular part of the cerebellum being affected. But probably the correct explanation is one which it is well you should recognise, because the same principle has to be used to explain the same feature with regard to other portions of the brain as well as the cerebellum. It is that it is possible for other parts of the nervous system to take on functions which have been abolished by disease in one part if time be given them. Probably the immediate effect of destroying all or part of the cerebellum is to produce a great interference with the functions of equilibration, but if the disease is a slowly developing one and the destruction is gradually produced, it is possible for other portions of the brain or nervous system to take on the functions ordinarily performed by the cerebellum.

The second symptom which gave us a clue as to the situation of the lesion was the absence of knee-jerks. As a rule, organic disease within the cranium is more likely to produce exaggeration of knee-jerk. This is probably on account of the likelihood of the lesion pressing somewhere on the motor path, and thus indirectly producing sclerosis of the lateral columns. Whenever there is sclerosis of the lateral columns the knee-jerks are likely to be exaggerated. In about twenty per cent. of the cases of cerebellar tumour which have been recently investigated the knee-jerks were found to be absent. If further investigation shows this to be distinctly connected with the destruction of the cerebellum it will be a matter of great importance, and a valuable assistance in the localisation of the intracranial lesions.

The reeling gait is what is called a direct localising symptom, that is to say it is the direct result of the lesion destroying a particular locality of the nervous system, to wit the cerebellum. It is probable that the absent knee-jerk is to be similarly explained. The enlarged head, however, which this boy possessed, if regarded as a localising symptom, must be called an indirect localising sign. It certainly is not a direct result of the cerebellum being destroyed, it is probably a secondary result of the tumour in the cerebellum causing an obstruction to the iter, so as to produce chronic hydrocephalus. The head does not often become enlarged as a result of the mere growth of an intracranial tumour; tumours are rarely large enough to increase the size of the head.

In the short time available for the investigation of this case at out-patients, no answer to the question, What is the tumour? was given. A conclusive answer to this question would be very valuable as a guide to the best treatment to pursue. The answer is to be sought by a consideration of history, both family and personal, and by investigation into the general condition of the patient. The fact that the tumour is situated in the cerebellum gives no clue to its nature, unless we admit the truth of a rather common statement, that cerebellar tumours in young children are more commonly

tuberculous than are intracranial tumours in other portions of the brain.

There are two sorts of tumours, the accurate diagnosis of which is of great assistance to treatment. If you are confident that an intracranial tumour is a gumma you may undertake its treatment by means of drugs with much confidence; if you are sure it is a simple cyst you may recommend surgical treatment with a light heart. But the points which will enable you to distinguish between these and other forms of tumour within the cranium are the same, whatever the situation of the lesion, and do not need special discussion in a case of disease of the cerebellum.

Calendar.

June, 1904.

Sat. 18.—Messrs. Symonds and Steward's take-in; Drs., A. H. Miller and G. H. K. MacAlister; Cl., E. S. Ward.

Thur. 23.—Messrs. Lucas and Lane's take-in; Drs., C. W. R. Preston and J. A. C. Greene; Cl., J. S. Cooper.

Thur. 30.—*Second Conjoint Exam. begins.*

July.

Fri. 1.—August and October Appointment List opened.
October Dental Appointment List opened.

Notes from Skin Outers.

Pediculi.

Pediculosis means "lousiness," and may be due to one of the following varieties of louse:—

1. Pediculus capitis.
2. Pediculus vestimentorum.
3. Pediculus pubis.
4. Pediculus palpebrarum.

1. *P. Capitis* is smaller than the other varieties and of a greyish colour (in Europeans—in negroes it is black); the ova (*nits*) form minute egg-shaped bodies firmly attached to the hairs. The disease is commonest in dirty, ill-kept children. The lice cause itching, the itching causes scratching, scratching with dirty nails causes pus-inoculation (*impetigo a pediculis*), pus-inoculation causes enlarged cervical glands, and enlarged occipital glands, frequently advanced to the stage of suppuration, are the cause of the small patient being brought to the hospital out-patient's by its mother—this is a common history. In extreme cases the hair is found matted together with pus, nits, and scabs, in a condition called *plica polonica*.

2. *P. Vestimentorum* is rather larger than the above and of a dirty white colour, and is the cause of the disease formerly known as *phthiriasis* or *prurigo senilis*. As opposed to P. capitis, P. vestimentorum is generally met with in elderly persons, and not necessarily in those of uncleanly habits (E. C. P.) Its habitat is the clothes rather than the skin; chiefly about the neck-band of the underclothing, but it feeds from the skin of its host by inserting a sucker into a sweat gland, to suck up blood, which operation leaves a "hæmorrhagic speck" only just perceptible to the eye and not at all to the touch (Crocker). A transitory wheal is also caused, but all other objective signs are due to scratching; thus linear scratch marks and later a leathery skin. These confined to the back of the neck and shoulders in elderly patients are practically diagnostic.

3. *P. Pubis* has a wider body than the two preceding varieties and is of a yellowish brown colour, hence the name in the vernacular of "crabs." These pediculi are chiefly found among the pubic hairs, but may also spread to the axillæ.

Associated with them, the affected portions of the skin are sometimes found to be covered with peculiar bluish stains about the size of the finger nail, said to be caused by the injection of a secretion of the vermin. These stains are called *taches bluêtres*, *taches ombrées*, or *maculæ caeruleæ;* they disappear when the pediculi are cured.

4. *P. Palpebrarum*, seen occasionally in very filthy children. These may possibly form a fourth variety of *pediculi*, or may be identical with P. pubis.

Treatment is of course directed towards destruction of the lice. Ung. Hydrarg, Ung. Hyd. Ammon., Ung. Naphthol G.H.P. (B. Naphthol in fine powder 1 part, Benzoated Lard 9 parts), and Lotio Ac. Carbol 1—40, are all useful applications.

In P. vestimentorum the clothes should be placed in a disinfecting oven or repeatedly boiled. In P. capitis and P. pubis it is not absolutely necessary to shave the parts, although it is obvious that this proceeding must facilitate the extermination of the pediculi. Near the eye paraciticides must be used with care.

Common sense will dictate the treatment of complications; thus, glandular abscesses necessitate opening, and cod-liver oil, or malt and iron will be indicated in the ill-nourished.

Testimonial to Dr. Eyre.

Preliminary List.

	£	s.	d.
Dr. T. Stevenson	3	3	0
Dr. L. E. Shaw	3	3	0
Mr. Clement Lucas	3	3	0
Mr. G. Rowell	2	2	0
Mr. F. J. Steward	2	2	0
Mr. G. Sichel	2	2	0
Dr. J. W. F. Jewell	2	2	0
Dr. J. H. Bryant	2	2	0
Mr. Dunn	2	2	0
Mr. Higgens	2	0	0
Dr. Craig	1	1	0
Dr. Fawcett	1	1	0
Dr. Eason	1	1	0
Mr. C. H. Fagge	1	1	0
Mr. F. G. Hopson	1	1	0
Mr. Wynne Rouw	1	1	0

With Dr. Shaw at Medical Out-Patients.

It would be hard to beat, for interest and variety, the first five cases chosen by Mr. Myer for Dr. Shaw's out-patients last Friday. The following notes indicate their chief features :—

1. A worker in a tannery, æt. 40, complained that he had been feeling ill for some weeks, and that a few days ago he had been attacked by a sudden acute pain in his left loin. He was very anæmic, had œdematous legs covered by a purpuric rash and hæmaturia. There was a loud systolic apical bruit. He was admitted to the hospital with a provisional diagnosis of ulcerative endocarditis with renal embolism.

2. The next case was a healthy-looking young man, who said he always enjoyed good health except for occasional weakness, and came to enquire if anything could be done to stop the hæmaturia from which he had persistently suffered for the last three years. The hæmaturia began when he was serving with the army in South Africa, and had at no time been associated with any symptoms indicating disease of bladder or kidneys. The urine was lightly tinged with the blood, and under the microscope the characteristic of ova bilharzia hæmatobia were easily recognised. The clinicals took the case in to investigate the disease and to try the most modern methods of treatment.

3. The third case was a man æt. 50, who had drunk about half a pint of rum daily for the last seven years except during a fortnight in each year, when he was suffering from an acute attack of gout. His left hand, which a day or two ago had been acutely painful, was now very œdematous and covered by the characteristic dusky red blush of podagra. There were no signs of any secondary effects of gout, nor of any other results of alcoholism. He was advised to increase the length of his period of teetotalism and was ordered Mist Colchici Cathart. ʒj. t.d.s.

4. A little girl, æt. 7, after a series of convulsions at the age of 18 months was noticed to hold her left arm stiffly. The left leg became stiff and the child always walked on the tip of the toes of the left foot. This condition had persisted till the present time, the only new feature being the development of almost constant involuntary movements of the left arm. A diagnosis of infantile hemiplegia with athelosis was made, Dr. Shaw pointing out that in this case the old name of post-hemiplegia, hemichorea, would be appropriate. It was stated that the treatment consisted chiefly in preventing rigidity and fixation of the limbs by passive movements and friction, and in encouraging voluntary use of the partially paralysed limbs. The history of the case negatived the congenital origin of the paralysis as the result of deficient development of the cerebral cortex, and also the possibility of its being due to any accidental intracranial hæmorrhage at birth, for the child appeared perfectly healthy till 18 months old. The infantile convulsions probably led to cerebral hæmorrhage.

5. The fifth case was that of a little girl æt. 10, whose left thorax was greatly contracted, so that the heart's apex beat was well outside the nipple-line. The physical signs idicated partial consolidation and excavation of the left lung, with compensatory emphysema of the right. The condition was diagnosed as fibroid lung with bronchiectasis. The mother stated that the child had always had a cough since she suffered at the age of three years from inflammation of the lungs. Dr. Shaw pointed out that although such extensive fibrosis of the lung occasionally followed broncho-pneumonia, it was more commonly produced by pleuritic effusion or empyema, especially when the existence of fluid was overlooked.

A Case of Pregnancy complicated by Adhesions.

A woman came to my surgery at 8 p.m. on the 16th inst. to enquire if she was pregnant. She was 39 years of age and had had one child 17 years ago. Menses had been regular until February this year; she thought she might be three months pregnant; no pain or any unusual inconvenience.

Abdominal examination revealed a swelling about the size of a three months' pregnancy, but the swelling was more towards the left than the right iliac fossa, and when this was pointed out to the patient she said that she had carried the first child in this manner. I told her that there might be a growth there, and advised an examination at home, she was quite willing, and left the surgery. Next morning her husband came at 9 a.m. and said she was dead. She had had a cup of tea at 6 a.m., and was getting up to do some washing, when she experienced a sharp pain causing her to cry out, and an attack of sickness ensuing, she vomited up some bread she had been eating; she laid down and died immediately.

Post-mortem.—The abdomen was full of blood, the uterus was bound down all over by firm fibrous tissue with the exception of a circular patch at the fundus, about two inches in diameter. A transverse tear had taken place, about three inches long, allowing a three months' fœtus to escape, which was found among the intestines; the uterine tissue was no thicker than ordinary brown paper at this part. The uterus could not be moved out of the pelvis until the knife had been used freely. When the adhesions were peeled off there were found to be several small subperitoneal fibroids; there were two submucous fibroids about the size of walnuts; the only part of the uterus that appeared to have stretched with the advancing pregnancy was at the fundus; the fundus lay at an angle of 45° with the middle line and towards the left side,

HENRY JOHNSON.

In Lighter Vein.

GAZETTE PRIZE COMPETITION.

"No doubt but ye are the people."
The Islanders.

RULES.

1. There is no necessity to repeat the quotation, simply put the number coupled with the name of the person to whom it is supposed to refer.
2. Address answers to Competition Editor, Gazette Office.
3. Sign your name in full, do not omit any Christian names, we always like to know them.
4. Send your list in before Dr. Dowie's next visit.
   (*a*) Enclosing with each lot six penny stamps.
   (*b*) Members of the Staff are requested to use black edged envelopes and to enclose twelve penny stamps.
   (*c*) Ladies free (*vide* Rule 3).
5. Each competitor may send in as many lots as he likes (*vide* Rule 4. Clause *a*).
6. The prize consists of A SCHOLARSHIP AT THE BOYCOTT LECTURES.

1. I never made a mistake in my life; at least not one that I couldn't explain away afterwards.
   Under the Deodars.

2. He turns a keen, untroubled face, back to the instant need of things.
   An American.
   . . . . . How my spirit cried
   To be an artless Bandar loose upon the mountain side.
   Divided Destinies.

3. Your attempts at sarcasm, which is essentially the weapon of a cultured man, are crude.
   To be filed for Reference.

4. If he had not been so objectionable one might have pitied him.
   Bisara of Pooree.

5. We shall pick out and discuss and dissect and evert and extrude to our mind,
   The flaccid tissues of long dead issues offensive to God and mankind.
   The old Men.

6. I have swayed troublous councils.
   I am wise in terrible things.
   The old Queen.
   Why, man, ye steer like a genius.
   Brugglesmith.

7. In his eye foreknowledge of debt.
   One Viceroy resigns.

8. The sort of face to dream about and try and carve on a pipehead afterwards.
   Cupid's Arrows.

9. Full of tales half remembered and very badly told.
   The Jungle Book.

10. We shall be perfectly pleased with our work.
    And that is the perfectest hell of it.
    The old Men.
    And almost thinks himself the Government.
    One Viceroy resigns.
    Oh God! Why 'aint he a man!
    The Man of Gloster.

11. By the gates of doom I sing,
    On the horns of death I ride.
    The Buoy Bell.

12. To me my King's much honour;
    Songs of Diego Valdez.

13. I see that you are a desperately unreasonable little woman.
    The Hill of Illusion.

14. Ye waste no wit in courtesy.
    The Last Rhyme of True Thomas.

15. Pink all over like a newly powdered baby.
    Under the Deodars.
    There's only one fault about you . . . . and that's thinking you know everything in the world and a little more.
    My Lord the Elephant.

16. Seeking a dole at the door.
    . . . Over and over the story ending as he began
    The Truce of the Bear.

17. As useless as a surcharged phonograph.
    The Truest Story in the World.
    He was stiff with books and theories and all manner of trimmings no manner of use.
    Archie McGoggin.

18. Get the dhoolies.
    The 'Eathen Recruit.
    Idle, openly idle.
    The Islanders.

19. . . . . Slow to dread or despise
Humble because of knowledge, mighty by sacrifice.

The Islanders.

By open speech and simple an hundred times made plain,
To work another's profit and seek another's gain.

The White Man's Burden.

20. One of these crazy people with only a single idea.

Germ Destroyer.

Making bad worse by ill language.

His Private Honour.

21. You'll break down because you are over-engined for your beam.

Archie McGoggin.

A New Method of Administration of Chloroform.

DR. PAUL CHAPMAN, of Hereford, has furnished us with a description of the instrument used by him in the operating theatre for the induction of anæsthesia by chloroform vapour, on May 16th.

The "Dubois" apparatus is in use in many physiological laboratories for keeping animals safely anæsthetised during prolonged observations. It was devised (in accordance with the knowledge that a mixture of $CHCl_3$ vapour with air in the proportion of 2 per cent. is (1) relatively free from danger, and is (2) just sufficient to produce complete surgical anæsthesia without reflex movements) in such a manner that a constant stream of a mixture of $CHCl_3$ with air, not exceeding 2 per cent., can be supplied through a facepiece, independently of any suction efforts on the part of the patient. There is a constant outflow from the facepiece, and the patient's expiration is also quite without obstruction.

The air is expressed from a small cylindrical gasometer containing four litres, by means of a piston working inside the cylinder. As the piston rises four litres of air are expelled above the piston and pass through a tube into the facepiece, at the same time air rushes into the cylinder below the piston. As the piston descends the action is reversed. The air below the piston now outrushes into the facepiece, and there is an inrush of air into the cylinder, above the piston.

When the apparatus is in use, the inrush of air always takes place closely over the surface of a few drops of liquid chloroform thinly spread out at the bottom of a vessel. By this means the few drops are completely vaporized (the vapour occupying some three hundred times the bulk of the liquid $CHCl_3$), and the vapour is intimately and uniformly mixed with the air in the cylinder.

It is necessary that the few drops of chloroform should be supplied in constant quantity, and that they should be instilled into the vessel just before each upward and downward movement of the piston previous to the inrush of air. Therefore use is made of the momentary dead-points occurring at the reversal of the upward or downward movements of the piston. The piston is moved by a wheel moving always in one direction, the reversal of the movement of the piston being automatic.

Projecting laterally from the circumference of the wheel are two little nuts which alternately catch (at the moment of the reversal of the movement of the piston) on the arm of a crank which moves a horizontal lever. At each thrust of the lever in a horizontal direction movement is imparted to a vertical screw, which conveys a slight downward movement to a plunger attached to it. The plunger dips into a small cylindrical vessel (clamped beneath it but easily detachable) containing when full some four ounces of liquid chloroform.

At each descent of the plunger a uniformly regulated number of drops of $CHCl_3$ run out of the vessel, through a lip projecting from the upper part of it, into the before-mentioned small vessel, through which the inrush of air passes and where it is wholly vaporised.

By means of a "cam" the horizontal movements of the lever can be made more or less excursive, thereby taking up fewer or more cogs connected with the vertical screw carrying the plunger. By this means it is easy to obtain, within minute limits, a faithful percentage of 1·2 per cent., 1·6 per cent., or 2 per cent. of chloroform vapour.

It will be at once seen that no reasonable excess of zeal on the part of anyone turning the handle can increase the chloroform percentage. Such a person may cause a needless waste of 2 per cent. chloroform vapour, embarrassing perhaps both to himself and to the operator, but he can do nothing worse.

As a detail, it is as well to warm the vessel containing the thin layer of liquid $CHCl_3$, so as to insure complete vaporisation, otherwise a lower percentage may be obtained. A spirit lamp is therefore supplied for this purpose, which warms the frame in which the vessel is held.

We should ask, Do we truly get a steady supply of 1·2, 1·6, or 2 per cent. $CHCl_3$ vapour by this means?

It is easy to attach a 250 c.c. glass bulb to the tube leading to the facepiece and fill it with a specimen of the vapour which the patient is actually inhaling. Now, each c.c. of $CHCl_3$ vapour weighs 4 mgrms. more than a c.c. of air. Therefore (in a 250 c c. bulb) 1 per cent. of $CHCl_3$ vapour would weigh $2{\cdot}5 \times 4 = 10$ mgrms.; 2·1 per cent. $CHCl_3$ vapour would weigh [2·1 × 2·5] (*i.e.*) $5{\cdot}25 \times 4 = 21$ mgrms., and so for all percentages.

In numberless estimations I have never succeeded in obtaining more than 2·1 per cent., and the variations on either side, for all percentages, are negligible.

My clinical experience is necessarily comparatively small, but I have never failed to produce complete surgical anæsthesia, always hitherto with a minimum of

anxiety to myself, and with as little inconvenience to the patient as seems to me to be possible, under the very varied conditions met with in each case. No less intelligence, and no less care, should be exercised when using definite percentage vapours than should be required of a ship's captain when his ship has emerged, but a moment ago, from a dense fog. He is still in a world of possible accidents.

Guy's Hospital Dental Society.

THE Annual General Meeting of the Dental Society was held on May 20th in the Physics Theatre. At first Mr. Dowsett occupied the chair, afterwards the President (Mr. W. A. Maggs). The minutes of the previous meeting were read and confirmed. The Hon. Sec. then read his report, which was adopted.

The Chairman announced that Mr. C. D. Wallis had been awarded the Society's Prize for his paper on "Evolution;" this award appeared to be a very popular one and was heartily applauded by all present.

Mr. A. E. D. Prideaux then, on behalf of the Dental Society, asked Mr. J. H. Badcock (who has recently resigned his position on the Staff) to accept four silver candlesticks, and a book containing the subscribers' names, as a token of their esteem and appreciation.

Mr. Badcock (who was welcomed with the greatest enthusiasm), feelingly referred to his regret at leaving the hospital. He also spoke of the good relations which had always existed between himself and all the students; and expressed the hope that although he was leaving he might see them from time to time.

The election of officers for the next season was then proceeded with, and the following were chosen:—President: Mr. R. Wynne Rouw. Vice-Presidents: Mr. W. A. Maggs, Mr. H. L. Pullin, Mr. M. H. Hopson, Mr. P. Turner, Mr. J. L. Payne, and Mr. P. S. Campkin. Hon. Sec. and Treasurer: Mr. J. W. Mawer. Committee: Messrs. Forty, Husbands, Snell, Shaw and Marsh.

A vote of thanks to the retiring President was then passed on the motion of Mr. C. W. Randall, and Mr. W. A. Maggs having suitably responded, the proceedings terminated.

Nursing News.

MATRON'S OFFICE.

On May 1st, Sister Katharine, Miss K. B. Webb, who has been acting as Night Sister, was transferred to Patience ward, and Miss Jessie Orr, who completed her training in April, 1901, and has since been on the Private Nuring Staff, was appointed Probationary Medical Night Sister.

On May 19th, Miss Edith M. Lewis, Sister Isolation, was transferred to Cornelius ward.

On May 2nd, Nurse Haslar, Head Nurse in the Theatres left the hospital on completion of her three years' training, and Probationer Jackson was appointed to succeed her as Head Nurse.

On May 14th, Probationer Gration was appointed Head Nurse in Queen ward.

On May 19th, Probationer Lear was appointed Head Nurse in Victoria ward.

On May 18th, Nurse Pearse, Head Nurse in Lydia ward, left the hospital on completion of her three years' training to take up her duties on the Private Nursing Staff. Probationer Neale has been appointed to succeed her as Head Nurse.

On May 27th, Nurse Plant was transferred to the Surgery as Head Nurse, and Probationer Maile appointed to succeed her as Head Nurse in Bright ward.

On June 3rd, Nurse Heritage left the hospital on completion of her three years' training to take up her duties on the Private Nursing Staff, and Probationer Elwin was appointed to succeed her as Head Nurse in Cornelius ward.

On June 11th, Nurse Crampton and Nurse Atkey, Head Nurses in Stephen ward, left the hospital on completion of their three years' training. Nurse Riley was transferred from the Isolation Wards to succeed Nurse Crampton, and Probationer Bonsor appointed to succeed Nurse Atkey. Probationer Powell was appointed to succeed Nurse Riley as Head Nurse in the Isolation wards.

Junior Guyite Club.

(Founded 1875.)

THE Annual Dinner was held at the Restaurant Frascati on the 29th April. President for 1904: H. Blatherwick. Vice-President: T. D. Lister. Members present: G. Newton Pitt, P. Horrocks, E. C. Beale, T. Brown, Chas. Sangster, R. A. Baillie, J. Fawcett, J. B. Howell, J. Curling Bates, G. H. Rodman, A. Kinsey Taylor, P. Warner, J. A. P. Price, Lockhart Stephens, P. W. Randall, E. C. Greenwood, Jas. A. Fraser, Hon. Sec. The following were prevented at the last from being present: A. G. Barrs, J. Cooper Wilkinson, G. Steele Perkins, J. Newland Pedley.

Six new members were elected.

The Hon. Secretary was requested to furnish the Editor of the GUY'S HOSPITAL GAZETTE with a copy of the above and to ask him to insert it in the GAZETTE.

It was decided to hold the 1905 dinner at the Restaurant Frascati on the first Thursday in May. President for 1905: T. D. Lister. Vice-President: J. A. P. Price.

JAS. A. FRASER, Hon. Sec.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Letters from a G. P.

No. 3.

SIR,—It may be urged that no one needs to be exhorted to look after his own interests, for I suppose that must be the reason why we get so little advice on the subject. We have it dinned into us, to do our duty to our patients and our profession, but what about our duty to ourselves? We have some claims for consideration, and there is an old saying respecting the commencement of charity. A doctor is often called in to settle some apparently trivial point, and if he cannot decide off-hand lays himself open to the charge of calling when there is no other reason than a pecuniary one, should he want to see the patient again before giving an opinion. Suppose one is asked to say whether any damage is done to a child's arm by a fall. It is all very well to say "Be honest and own to being uncertain," but your credit will suffer and no one will gain by so doing. If you are uncertain, treat it as fracture until you can make certain. A patient who found after a week or two that his fibula was fractured, felt very hurt, and employed his convalescence in walking about the neighbourhood publishing his own ideas on his doctor's merits. Such a case is difficult, and one cannot delay for more than a few days before giving a final opinion and instituting a line of treatment, and in spite of a little extra inconvenience to the patient, it is a duty owing to oneself to safeguard one's own interests and give the patient the burden of the doubt. This is only one instance of many like occasions, both medical and surgical, and it is better to be an alarmist than the reverse, unless one has attained the credit of infallibility which long residence in a place sometimes brings.

Very many patients have a great liking to diagnose their own condition. Unless you have the best of reasons to contradict it, refrain. It is awkward to break down a cherished idol and have none other to set up. To the pained query, "Well, what is it then?" an answer of "Oh, I don't know, but it is not that," is hardly convincing from a patient's point of view although it is perfectly honest.

When one thinks of the reputations that have been wrecked over babies, it is wonderful that many men shirk their opportunities of gaining experience. The result is much the same as with the dramatic club which excuses its lack of energy in rehearsing and fondly says, "Oh, it will be all right on the night."

I know a man who is always cheerful in adversity because he has gained experience, and it is one of his axioms that all experience must be paid for. I think that there is a good deal to be said for this view, but I should like to add that this commodity has no fixed price. In the medical world a man pays the top price at home, so let him get his experience as far away as possible, in short, buy in the cheapest market but I will pause before I get any nearer the Fiscal question —I may be drawn in unawares.

I often think that an ideal system of training should follow in the lines of the schools of the Jesuits. We should train a man to fit a place. I have heard of men who say that a medicine man should study medicine, and if he had any spare time, study more medicine. Can anyone picture the result? Such a man should not be allowed to go into general practice where he would have some social obligations. He is only a machine, and is fitted to some small specialism where he could run rampant and magnify every mole-hill into a mountain. It would be like tearing a plant from its roots to send him to a place where they had no Maze Pond Surgeon Barbers' Association or Bermondsey Rhinoscopical Society where he could charm his audience, or in turn be charmed, on most nights of the week.

A general practitioner is rather like the man Mr. Kipling saw "spitting in the ditch aboard the Crocodile," soldier and sailor, too. He has of necessity to be master of several arts and sciences, call them what you will, and then he is the family doctor. But he is in a considerably better situation if he is also the family friend, and I defy the most charitable to take their doctor for a friend if he is wrapped up entirely in his own work. No one can deny that an occasional scrap of medical knowledge has an enormous fascination for the lay palate, but few of them will feed on it. If a man has any artistic taste at all it is worth cultivating, if only from a commercial point of view. Should you be able to talk music or books you will make a place where your medical knowledge may afterwards flourish and bear much fruit. A few parlour tricks are of more use to a young man than half a page in the directory.

Think, now, sir, how nice my system would be say for the budding country G.P., who would study the elements of agriculture in the park under the able tuition of Dr. ————, *he would, I am sure, talk as glibly on this* as on any other subject. Mr. Betts could discourse on pigeons, and I daresay that some one could be found who would uphold the merits of the domestic cat.—I remain, Sir, yours faithfully,

WORLDLY WISEMAN, M.D.

An Acknowledgment.

Mrs. Toogood-Hill desires to express her thanks, and gratitude to the members of the Hospital, for their great kindness in presenting her with such a handsome clock and beautiful lace bedspread. She felt it a most delightful surprise to find she had so many kind friends who regretted her leaving Guy's. She is leaving as the Medical School Committee have abolished the post of an Artist, which she held for the last ten years.

HENRIETTA MARIA TOOGOOD-HILL.

The Chantry, W. Enfield,
June 12th, 1904.

Another Pointless Fable.

"I say, mister, I ain't dead yet."

The Perforated Gastric Ulcer was standing in front of a Borough fruit shop, eating black-heart cherries and looking the picture of aggressive impertinent good health. He appeared to be grieved, and wanted explanations.

"They said I was necropsied, mister," he remarked, and then added, with Swinburnian alliteration, that he was "livin' on mutton and milk puddin's which his missus made."

"There aint nothin' like them newspaper chaps for makin' mistakes," he observed sententiously, "a'-writin' they don't know what of. They made a perfect job of me, mister, up at the 'Orspital, and after the other chaps had given me up."

He took another handful of cherries and seemed royally oblivious to the stones.

"Talk of havin' sponges and such like things left in one's insides," he said, with his mouth full, "It don't matter to me. They never did nothing of the kind to me, mister. Its rare comfortable I am now. There ain't nothin' like them surgeons."

"What about leather?"

"Leather's very well if you're a bootmaker like," he replied, "But it ain't in it when you come to my job, I'm a show case—and they said I was dead."

He shook his head mournfully, and walked towards Walworth, very much alive, to be in time for his missus' milk puddings.

[The above fable seems altogether too pointless, unless it be in the nature of a sop to Cerberus.—ED.]

From the Gazette's Special Pathologist.

NOTICES.

C. F. W., HORLEY.—Tubercle bacilli are present in considerable numbers in this specimen of sputum.

PATHOLOGIST.

Reviews.

The price of books submitted for review should in every case be stated.

Report of the Board of Health on a Second Outbreak of Plague at Sydney, 1902 (New South Wales Legislative Council). By J. Ashburton Thompson, M.D., D.P.H., President, Chief Medical Officer of the Government. Sydney: William Applegate Gullick, Government Printer, 1903. pp. 80, 28 tables, 4 diagrams, 2 plates. 2s. 6d.

We have recently received the Report on the second outbreak of Plague at Sydney, compiled by the President of the Board of Health, Dr. Ashburton Thompson (who by the way is an old Guy's man), which brings out in a most forcible manner the close association between plague amongst rats and the epidemic form of the disease in man. The report itself is written in the form of short consecutively numbered paragraphs grouped under three headings, whilst a list of cases is appended, with the numbers of the paragraph dealing with each case, which renders the work of reference quite easy. The first two sections deal with the epidemic and its mode of spread respectively; the third discusses the epizoötic in relation to the epidemic.

Plague first appeared in Sydney in January, 1900, lasted until August of the same year, attacked 303 individuals (of whom 103 died), and cost the city some £176,000. As Dr. Ashburton Thompson remarks more than once in his present report, an epidemic disease such as plague can be studied by the epidemiologist in Sydney, by similar methods and with all the exactitude attainable in an English town, that is to say, under conditions vastly different from those obtaining in crowded Asiatic cities. Consequently, the first epidemic of plague furnished the health authorities of Sydney with such suggestive information as to its causation, and its mode of spread, as to enable them to formulate a definite policy—a policy which was promptly carried out when plague again made its appearance in November, 1901, in all probability again introduced from over-sea by rats. This second epidemic lasted until June, 1902, during which period 139 cases occurred (with 39 deaths), the cost on this occasion being but £24,000. Dr. Thompson gives many details of the cases comprised in this epidemic and explains the means employed in fighting it. These latter may be briefly summarised as systematic destruction of rats in infected areas; observation and treatment of the sick in rat-proof wards of the Infectious Diseases Hospital; extremely lenient supervision of "contacts," and disinfection of infected houses and areas with as little interference as possible with the freedom of residents and the general population. In this part of the report Dr. Thompson presents the facts to the reader practically in the order in which they were observed and in so impartial a manner that it is difficult to ascertain the value or the interpretation he places upon the many discordant observations.

The Report of the Plague Research Committee (an abstract of which appeared in the GUY'S HOSPITAL GAZETTE, 1898, pp. 379 and 415), also the report of the Plague Commission in India, 1901, created the distinct impression that the efficient causes of epidemic plague were (*a*) communication of infection from the sick by direct means; (*b*) by indirect means; and (*c*) place infection (*e.g.*, houses or areas into which the infection of plague has been imported by men or rats are infective). Subsequent observation has shown, however, that apart from its pneumonic form, plague is not highly contagious. In the Sydney epidemic not only did no pneumonic cases occur, but none of the cases could be ascribed with any degree of probability to direct contagion. Similarly, no evidence of transmission of plague infection from sick to healthy by means of rats, clothing, etc., could be traced. Finally, place infection, as defined above, had obviously but little to do with the spread of the disease, for of the 139 cases comprised in the epidemic, no less than 115 were derived from as many separate and distinct premises—only nine premises yielded two or more cases. The more modern view of the etiology of plague, viz., that it is essentially a disease of the rat, which is transmitted from rats to men, receives, however, strong support from the observations of Dr. Thompson, and in the third part of his report he emphasises the evidence in favor of this hypothesis. For example, the bacteriological examination of the rats collected by the official rat-catchers afforded ample evidence of the general coincidence in time and locality between the occurrence of plague in rats and the appearance of bubonic plague in man.

Again, in the few premises that yielded two or more cases during the epidemic, the connecting link noted between these various cases was the fact that such premises were infested with plague stricken rats.

But as Dr. Thompson points out, plague rats were frequently found infesting premises to which no cases of plague in man were ever traced, and from this and other observed facts he argues that some special means is necessary for the transference of the plague infection —*B. pestis*—from the rat to man. This special means, he agrees with Simond, is most probably one or other of the ectoparasites of the rat. Dr. Tidswell, the government micro-biologist, who was responsible for the examination of the rats collected, noted that fleas were very abundant alike on healthy and sick rats during the epidemic, but that after the subsidence of the epidemic the number of fleas observed rapidly diminished. The fleas represented some four species which have been identified by Dr. Tidswell, and of these, three species were proved to be capable and willing, at any rate when driven by hunger, to attack man—observations directly opposed to the results of the much less exact observations of Nuttall and Galli Valerio. On the other hand, experiments devised to secure the transference of plague from inoculated to healthy guinea-pigs by means of rat fleas, failed to give positive results.

In spite, however, of this lack of direct evidence, Dr. Thompson brings so many weighty arguments in support of his contention, that we are inspired to hope that the experiments now proceeding in Dr. Tidswell's Laboratory will be productive of results which will once and for all settle the vexed question of the guilt or innocence of the ubiquitous flea.

To those of our readers who are interested in the epidemiology of plague, we strongly recommend the perusal of this report, which has now been placed on the shelves of the Wills Library.

A Dining Room Dialogue.

(It has become the fashion lately to apologise to somebody for everything one writes, as if every kind of story or dialogue were the property of some writer who has done something similar before. I, therefore, desire to apologise to Mr. Keble Howard, the "Daily Mail," he writer in a recent number of the GAZETTE, to everybody who has ever written dialogue of any sort before, and especially to all who trouble to read these pages.)

(*Scene: The College Dining Hall. Time, 7 p.m. Enter Guy's man accompanied by a visitor in the person of his genial uncle*).

G. M. Shall we sit here and have the table to ourselves?

G. U. Certainly. College dinner, you say? Three courses and coffee? That will suit me admirably. But I like that long table at the end of the room. I shall see better there. Shall we change?

G. M. Oh, that's a rotten table.

G. U. But I like the position. Shall we sit there instead of here?

G. M. Well, you see we can't—that is, we're not *supposed* to sit there. It's for the Residents.

G. U. The Residents! Who are they?

G. M. (*In tone of jealous contempt, at the bottom of which may be detected a substraction of respect*). Oh, only H.S.'s and H.P.'s. Have some soup? (*They proceed to order soup, whereupon the waitress informs them that she cannot serve college dinners at a side table. G. M. expostulates. The waitress is firm. G. M. appeals to a higher authority. The H. A. supports the waitress and they move to the centre table*).

G. U. (*jovially*). I used to know a lot of medical students in my young days. Gay dogs some of them too. Always ready for a lark and up to any excuse to avoid their work.

G. M. (*in horror*). Avoid their work! They must have been slackers.

G. U. Some of them were very good fellows.

G. M. Slackers *and* good fellows!! How could that be?

G. U. Well, all work and no play—you know the rest.

G. M. That's nonsense. I am always working. I never play anything, and look at *me*. (*G. U. looks and decides to change the subject*).

G. U. Who was that fellow who just passed. He said good evening to you, but you didn't see him.

G. M. Oh, yes, I saw him, but I didn't notice him. Beastly cheek of him speaking. He was my ward clerk.

G. U. I understand. Some menial. But why are such people allowed to dine here?

G. M. Oh, all students have the right. It's a great shame, I confess.

G. U. (*in surprise*) Is he a student? But I thought from your manner——

G. M. You see, none of the *best* men here ever recognise their ward clerks. It only makes them conceited and forward if we do. He was a clerk when I was dressing and now I have finished all my appointments. We must have *some* sort of distinction between the best men and our inferiors.

G. U. Then I suppose you were never a ward clerk. If so—— (*He is interrupted by a blow on the cheek from a piece of bread thrown by one of the diners*). Hulloa! What was that?

G. M. Only a piece of bread. A lot of men throw bread about at dinner time.

G. U. Dear me! Is it some old custom?

G. M. No, the Residents do it because they *are* Residents, and the others who throw are men who *hope* to be Residents one day.

G. U. (*rubbing his cheek*). I can't say I like the habit.

G. M. Oh, it's quite all right, I assure you. I do it myself sometimes.

G. U. Does that mean that you want to be a Resident?

G. M. Oh, no. I can easily manage that when the time comes, if I choose. Not that the best men get the appointments by any means, but I have no fear of their passing *me* over in spite of the fact that the Staff are a bit jealous of me.

G. U. Jealous of you!

G. M. Yes. They like a man to know something, but they don't like a man to know too much. Do you see?

G. U. Oh, yes, I think so. Then I gather that the present Residents don't know too much, eh?

G. M. Too much! Some of them know nothing. It was a fearful shame Brown getting H. P. I taught him all the medicine he knows. And as for Jones the H. S., well, he would have been in a nice hole once if I hadn't been on the firm. I'll tell you of a mistake he made one day (*proceeds to give graphic and uninteresting details of Jones' blunders*).

G. U. (*who is tired of listening to the tale of Jones' incompetence*). By the way, have you been to the Academy this year?

G. M. Academy. Oh, no. Fearful waste of time looking at pictures. Now what *I* do is to——.

G. U. I'd forgotten, of course, that you have so much work to do.

G. M. Work! Rather. You would hardly believe it but I read 300 pages of Rose and Carless last night. Not many men can do that. I felt as if I were going off my head when I'd finished. I don't want to boast, but that was pretty good, wasn't it?

G. U. Yes, I suppose so. Talking of books, do you know Bernard Shaw at all?

G. M. Shaw? No. What year is he in?

G. U. I mean George Bernard Shaw, the author of——.

G. M. (*interrupting*). Oh, I thought you were talking of a Guy's man. No, I never read anything beyond my work. I'm glad to say that I'm not a slacker.

G. U. I see you derive great comfort from that thought.

G. M. Rather. The result is I'm well up in my work. Shall I tell you what happened in the Front Surgery the other day? (*A long story of what didn't happen follows, in which the speaker lays great stress on his skill in diagnosis and other similar accomplishments.*)

G. U. You seem well up in your work.

G. M. Oh, yes, I am, though of course I don't like to talk about it myself, but I'm running the front to-morrow evening for a friend. Would you like to see me?

G. U. (*quickly*). I'm afraid I cannot, thank you. The fact is I am going to the theatre. I rather thought you would like to come.

G. M. I hardly ever go to the theatre. The last time I went, though, we read medicine and asked each other questions between the acts. *I* thought of that. Jolly good idea, wasn't it? But then I—— (*A large piece of bread at this moment falls on the table breaking a glass, a piece of which strikes G. U. in the eye.*)

G. U. Something struck me in the eye then. Did you see it?

G. M. It's all right. It wasn't meant for you. But the clinicals are such rotten shots. It's given you a nasty cut, hasn't it? Press your handkerchief on it to stop the bleeding. Talking of bleeding, I'm reading a paper on Hæmorrhage at the Physical Society shortly. I'm awfully well up in the subject. I'll put on an H.B.F. for you after dinner. I'm awfully good at eyes. I——.

G. U. (*whose geniality is fast giving place to nervousness*). Shall we move our seats? It looks safer over there. (*They reseat themselves at the side table. Waitress promptly orders them back again, reminding them they are having College dinner. G.M. grows angry, says he will sit where he likes, declares he will write to the "Gazette." mutters something about not allowing himself to be sat upon and—goes back to the centre table.*)

G. U. It seems strange that the waitress should choose your seats for you in your own club.

G. M. Isn't it so in all clubs?

G. U. Well, hardly.

G. M. Of course, it would be all right for a junior man. But when a man has done all his appointments like I have——

G. U. Quite so.

G. M. Shall we go across to the Front Surgery now for that H.B.F.? I'll just change my coat for a Norfolk.

G. U. A Norfolk?

G. M. Yes, I always wear a Norfolk coat in the Front Surgery. It impresses the clerks. Besides, I may apply for an appointment later and they never give appointments to men unless they wear Norfolk coats.

G. U. That seems odd.

G. M. Not at all. Only the *best* men wear Norfolk coats, so it's quite easy. Do you see?

G. U. Nothing could be clearer.

G. M. After that I shall go into the wards and talk to the nurses. I generally do that at night time. It's a treat for the nurses and they appreciate it. It's dull for them at night time. They give me tea and toast, as a bribe, I suppose.

G. U. But if many men go every night——

G. M. But they don't. Only the *best* men go. I don't want to appear conceited, but I must say that I am very popular with the nurses. (*Long recital of his numerous conquests in various wards follows.*)

G. U. Ah, I see! Quite a lady's man.

G. M. No, I wouldn't put it that way. It isn't my fault I'm popular. Besides, I often find women very dull. I was at a dance not long ago and took a pretty girl into supper—the prettiest girl in the room. I told her about my patients and explained to her the working of the sphygmograph. She didn't seem a bit interested. But they say women don't like clever men, of course their brains are smaller, that's a physiological fact. (*G. U. comments on the stupidity of women in suitable terms*).

G. M. Talking of physiology, I want to tell you——

G. U. No, not now. Had we not better go?

G. M. All right, I'll put on that H.B.F. for you now. Do you know there are very few men who can put on an H.B.F. properly. I remember putting on my first, one of the Staff said——

G. U. By the way, what is an H.B.F.?

G. M. You don't know what an H.B.F. is! You don't know! Why every ward clerk knows that.

G. U. (*irritably*) But I'm not a ward clerk.

G. M. Of course. How thoughtless of me! You haven't had the advantage of a medical education, have you?

(*They go out G. M. talking of fomentations in unnecessarily loud tones, whilst G. U. follows meekly, thoroughly convinced that all medical students are not the jolly fellows he once thought them*).

Pass List.

University of Cambridge, June, 1904.

BACHELOR DESIGNATE IN MEDICINE AND SURGERY.

C. R. Howard.

Royal Army Medical Corps.

H. B. German, G. Moir, F. R. Featherstone.

Sport.

Wednesday, June 22nd.

Guy's Hospital Athletic Sports at 2.30.

CRICKET FIXTURES.

Saturday, June 18th.

G.H.C.C., I., v. London County C.C., away 11 a.m.
" II., v. Addiscombe "A," home, 2 p.m.

Wednesday, June 22nd.

" II., v. Manor House School, away, 2 p.m.
" III., v. Boro' Road College "A," away, 2 p.m.

Saturday, June 25th.

" I., v. Past, home, 11 a.m.
" II., v. Old Colfeians, away, 2 p.m.

Wednesday, June 29th.

" II., v. Crofton Park, home.
" III., v. Brentwood Grammar School, away, 2 p.m.

Saturday, July 2nd.

" I., v. Gravesend, away, 11 a.m.
" II., v. R.I.E.C. "A," home, 2 p.m.
" III., v. Boro' Road College "A," away, 2 p.m.

LAWN TENNIS FIXTURES.

Saturday, June 18th.

G.H.L.T.C., I., v. Wanstead, away.

Wednesday, June 22nd.

" I., v. Blackheath "A," home.

Saturday, June 25th.

" I., v. Brixton Wanderers, away.

Saturday, July 2nd.

" I., v. Brixton Wanderers, home.

POLO FIXTURES.

Friday, June 24th.

G.H.S.C., v. Old Alleynians, away.

Friday, July 1st.

" v. Thornton Heath, home.

Cricket.

GUY'S v. REIGATE.

Played at Reigate on Saturday, May 28th, the home side winning an exciting match by 1 run. Scores:—

GUY'S.	
J. S. Bookless, c J. W. Neale, b R. Neale	2
H. D. Wyatt, b Davis	35
R. Willan, st Walters, b R. Neale	26
T. Husbands, b Davis	18
A. M. Tolhurst, run out	0
H. Archer, c Davis, b R. Neale	17
L. G. Davies, b J. W. Neale	15
E. Whelan, lbw Davis	0
B. H. Stewart, run out	3
S. M. Wells, not out	26
S. A. Piper, c J. W. Neale, b Davis	5
Extras	7
Total	154

REIGATE.

J. W. Neale, c & b Wyatt	1
F. Nightingale, c & b Wyatt	6
F. J. Nightingale, c Stewart, b Piper	14
—. Davis, b Piper	46
H. D. Walters, c Archer, b Piper	14
R. W. Neale, not out	40
F. J. Clayton, b Willan	3
C. S. Tolly, c Willan, b Wyatt	17
H. Trower, c Archer, b Wyatt	3
R. C. Neale, c Willan, b Wyatt	0
D. Killick, run out	1
Extras	10
Total	155

GUY'S v. HAMPSTEAD.

Played at Hampstead on Wednesday, June 8th. Scores:—

GUY'S.

H. Sims, b Marsden	6
J. Bookless, c Beaton, b Hickson	18
R. Willan, b Hickson	6
E. Whelan, b Marsden	0
H. D. Wyatt, b Marsden	72
A. Leeming, b Marsden	8
H. Archer, c Beaton, b Holland	12
S. M. Wells, c & b Marsden	6
J. L. Johnstone, lbw Holland	0
R. W. Allen, lbw Holland	1
S. A. Piper, not out	10
Extras	15
Total	154

HAMPSTEAD.

G. A. S. Hickson, b Bookless	101
C. E. Barnett, b Wyatt	12
H. Wade, st Wells, b Allen	45
L. Holland, b Willan	20
E. L. Marsden, b Allen	9
E. W. Beaton, b Leeming	5
F. Rowley, c Archer, b Piper	36
M. De Lissa, b Leeming	5
J. C. Toller, c Allen, b Wyatt	49
C. D. Drayson, b Willan	17
V. C. Holland, not out	0
Extras	20
Total	319

GUY'S v. CHARING CROSS.

INTER-HOSPITAL CUP.—2ND ROUND.

Played at Chiswick on Thursday, June 9th.

Winning the toss, Wyatt took Barber in with him to open the innings. Wyatt soon started to score, but, with the total at 53, was caught at slip for 33. Barber was out in a similar manner 5 runs later. Willan and Bookless then made a stand and sent the 100 up before Bookless was out. Husbands helped Willan to add 90 for the fourth wicket, when the former was caught at third man. Lunch was then taken, Willan being not out 82. On resuming, Willan reached his century, and, with Tolhurst hitting the bowling all over the field, runs were put on at a great pace, Willan left at 303. Archer quickly hit up 50 when he was struck by a rising ball and had to retire, Simms took his place. Tolhurst reached his century soon after and the innings was declared closed with the score at 413 for 7 wickets.

Charing Cross started their innings at 4 o'clock against the bowling of Davies and Wyatt; the first wicket fell at 30, but with Williams and Huxtable together runs came easily; a double change in the bowling was tried, Huxtable being well caught at mid-off for 31; 3 wickets then fell quickly, but with Williams and Beaman together a long stand was made, although few runs were obtained. At length Williams was splendidly caught in the long field for a good innings of 48. The end soon came after this, leaving us winners by 271. St. Mary's have to be met in the semi-final. Scores:—

GUY'S.

H. Barber, c Hugo b Blythman	19
H. D. Wyatt, c Williams b Blythman	33
R. Willan, c Keyworth b Huxtable	129
J. S. Bookless, c Huxtable b Blythman	22
F. H. Husbands, c Hugo b Lucas	35
H. Archer, retired hurt	50
A. M Tolhurst, c Beaman b Lucas	102
H. Simms, not out	10
Extras	13
Total (7 wickets)	413

L. G. Davies, S. M. Wells, S. A. Piper did not bat.

CHARING CROSS.

R. Huxtable, c Wyatt b Willan	31
W. D. Keyworth, c Barber b Wyatt	8
D. P. Williams, c Archer b Wyatt	48
G. B. Lucas, c Wells b Piper	0
R. S. Blythman, c Wells b Piper	0
J. W. Evans, b Piper	0
W. K. Beaman, c Simms b Piper	19
T. Story, not out	6
E. H. Hugo, c Wells b Wyatt	5
J. Tilly, lbw Wyatt	0
P. Stibbe, c Wyatt b Davies	0
Extras	25
Total	142

GUY'S 2ND XI. v. OLD COLFEIANS.

This match was played on our ground on Saturday, May 14th, resulting in a win by 34 runs. Scores:—

OLD COLFEIANS.

E. F. Milton, c Evans, b Verver	6
H. E. Bills, c Wells, b Bartlett	24
D. Denny, b Rice	5
Ironside, run out	10
H. C. Denny, lbw, b Bartlett	42
Whibley, b Moyle	2
Naylor, b Bartlett	0

Ross, b Moyle	3
T. Coppinger, b Moyle	5
Smither, st Iliffe, b Moyle	1
W. Coppinger, not out	0
Extras	19
Total	117

GUY'S.

H. Barber, b Ironside	10
T. L. Johnson, b Ross	6
O. G. Iliffe, b Ross	24
L. W. Evans, lbw b Ross	11
S. M. Wells, b Whibley	18
H. H. Carter, b Ross	3
T. R. Harvey, b Milton	27
H. H. Moyle, c Denny, b Bills	0
B. T. Verver, lbw Ironside	6
G. E. Rice, b Ironside	11
G. N. Bartlett, not out	14
Extras	21
Total	151

GUY'S 2ND XI. v. OLD OLAVIANS.

This match was played at East Dulwich on May 21st. We were easily beaten on the first innings. Scores:—

GUY'S.

E. L. Norton, c & b Krauss	1
R. W. Allen, c Barton, b Krauss	2
R. S. Bennett, c Wilson	21
M. Munden, b Powell	3
S. M. Wells, c Wilson, b Krauss	4
G. N. Bartlett, b Lowe	34
A. M. Bennett, st Brownlow, b Wilson	8
Munden, b Lowe	5
G. Evans, b Wilson	0
Vicary, b Wilson	0
Morris, not out	0
Extras	2
Total	80

OLD OLAVIANS.

Trowell, b Morris	58
Lugg, c Bartlett, b Morris	0
Brownlow, not out	54
Krauss, b Bartlett	3
F. Lowe, not out	9
Extras	3
Total (3 wickets)	127

C. D. Wilson, G. Lowe, Howard, Sutherland, Barton, Powell, did not bat.

GUY'S 2ND XI. v. THESPIDS.

This match was played at Honor Oak Park on June 10th. Our opponents batting first compiled 185, the last five wickets doing well. Our score was 105, of which Norton made 28, a very useful innings. For the Thespids, C. A. Smith played a good innings. Scores:—

THESPIDS.

V. O'Connor, c & b Wyatt	2
Leslie Holland, c Mutch, b Wyatt	11
C. A. Smith, c Litchfield, b Wyatt	54
V. Harsand, c Neuman, b Bartlett	17
B. Egerton, c Strange, b Wyatt	0
Horace Mills, c Wyatt, b Strange	29
F. Stayton, run out	10
H. Nye-Chart, not out	24
A. G. Stacey, c & b Bartlett	0
P. Darwin, b Wyatt	5
A. S. Homewood, c Wyatt, b Morris	18
Extras	15
Total	185

GUY'S.

A. Newman, c Nye-Chart, b O'Connor	7
E. L. Norton, c & b Smith	28
H. H. Moyle, b Holland	0
H. Archer, c Holland, b O'Connor	1
H. D. Wyatt, b O'Connor	14
O. G. Iliffe, b O'Connor	5
S. Mutch, c Nye-Chart, b Smith	3
E. W. Strange, c & b O'Connor	17
B. H. Stewart, b Smith	13
P. C. Litchfield, b Smith	5
G. N. Bartlett, not out	7
C. Morris, b O'Connor	0
Extras	5
Total	105

GUY'S 2ND XI. v. NORBURY PARK "A."

This match was played at Honor Oak Park on Saturday, June 11th, ending in a draw in our favour. Scores:—

GUY'S.

H. Barber, b Langton	82
A. Leeming, b Guttey	35
E. L. Norton, c Hicks, b Guttey	49
R. S. Bennett, c Langton, b Guttey	8
R. W. Allen, b Langton	10
T. R. Harvey, not out	6
J. L. Johnstone, lbw Langton	5
Extras	26
Total (6 wickets)	221

Innings declared closed.

S. Mutch, H. H. Moyle, G. N. Bartlett, G. E. Rice did not bat.

NORBURY PARK "A."

J. V. A. Hicks, c Bartlett, b Rice	69
A. K. Williams, b Rice	7
J. A. Archer, b Rice	10
F. C. Wight, b Bartlett	12
E. R. Langton, lbw Moyle	4
R. H. Wyatt, b Bartlett	28
J. W. Macaldin, not out	0
J. V. Read, c Rice, b Bartlett	0
W. V. Guttey, not out	4
Extras	14
Total (7 wickets)	148

G. L. Holmes, G. A. Taylor did not bat.

GUY'S 3RD XI. v. SEVENOAKS SCHOOL.

Played at Sevenoaks on Wednesday, May 11th, and ended in a win for Guy's by 40 runs. Elliott batted well for his 39, and Morris took 9 wickets for 21 runs Scores:—

GUY'S.

L. J. Johnston, lbw Armstrong	12
H. H. Carter, b Denning	12
E. Elliott, c Rigby, b Denning	39
H. H. Moyle, c Denning, b Ingles	0
T. R. Harvey, c Rigby, b Ingles	2
G. L. Rice, c Patterson, b Rigby	10
D. Reynolds, c & b Rigby	0
C. Morris, b Rigby	0
H. R. Bastard, not out	10
—. Townrow, c Armstrong, b Denning	1
H. N. Eccles, b Rigby	0
Extras	9
Total	95

SEVENOAKS SCHOOL.

F. H. Ingles, c Harvey, b Morris	9
L. A. Vardon, c Reynolds, b Morris	1
R. L. Patterson, b Morris	2
P. Rigby, c Elliott, b Morris	6
G. E. Armstrong, lbw Morris	8
S. G. Stevenson, lbw Morris	5
P. Welch, b Morris	10
S. F. Pearson, lbw Morris	0
C. W. Denning, not out	5
H. Armstrong, c & b Morris	0
K. Wood, lbw Elliott	3
Extras	6
Total	55

Guy's Hospital Rifle Association.

First Armitage shoot. Shot at Wraysbury on May 18th. Scores:—

Yds.	200	500	600	Total.
G. C. F. Robinson	33	33	30	96
R. E. French	33	32	27	92
R. Felton	30	26	25	81
G. A. Ticehurst	28	29	20	77
W. E. Freeman	24	22	24	70
J. A. Wishe	20	23	25	68
Grand Total				484

St. Thomas's Hospital made 456. St. Mary's and St. Bartholomew's did not bring down full teams.

Second Armitage shoot. Shot at Wraysbury on Wednesday, May 25th.

Yds.	200	500	600	Total.
G. C. F. Robinson	32	31	31	94
R. E. French	26	33	30	89
R. Felton	29	22	23	84
G. P. Minett	25	21	30	76
J. A. Wiche	28	21	22	71
M. M. Adams	24	24	22	70
Grand Total				484

St. Bartholomew's Hospital made 496. St. Mary's and St. Thomas's did not bring down full teams.

Guy's Hospital Lawn Tennis Club.

On Saturday, June 4th, Surbiton "A" beat us on their ground by seven events to two.

F. Palmer and Orpen lost to F. and W. Walker, 4–6, 1–6; lost to Nye and Hopkins, 4–6, 7–5, 3–6; beat Bele and Durham, 6–3, 6–3. Zorab and Morris lost to F. and W. Walker, 4–6, 2–6; lost to Nye and Hopkins, 8–10, 3–6; beat Bele and Durham, 4–6, 6–4, 6–4. A. Palmer and Adams lost to F. and W. Walker, 1–6, 2–6; lost to Nye and Hopkins, 0–6, 2–6; lost to Bele and Durham, 1–6, 1–6.

On Saturday, June 11th, Kent beat us at Honor Oak Park by seven events to two.

F. Palmer and Zorab lost to W. Heelas and Escombe, 4–6, 3–6; beat Colquhoun and Oldfield 6–4, 10–8; beat R. Heelas and Cousins, 6–3, 6–8, 6–1. Orpen and Morris lost to W. Heelas and Escombe, 2–6, 2–6; lost to Colquhoun and Oldfield, 5–7, 1–6; lost to R. Heelas and Cousins, 4–6, 1–6. A. Palmer and Barker lost to W. Heelas and Escombe, 3–6, 3–6; lost to Colquhoun and Oldfield, 3–6, 3–6; lost to R. Heelas and Cousins, 5–7, 0–6.

So far our first team has not distinguished itself, having lost five consecutive matches without a single victory. The team as a whole have played very badly, and must improve considerably if the least success is to be achieved in the Hospital Cup Ties.

The Second VI. were beaten by East Sheen "A" by nine events to love, but against St. Thomas's "A" they were more successful, beating them by five events to four.

The draw for the Inter-Hospital Cup Ties is—

St. Thomas's - - A bye
St. George's - - A bye
Middlesex - - }
London - - - }
Guy's - - - A bye

To be played at Chiswick on June 22nd, 23rd, 24th

Births.

BROWN.—On May 31st, at Carlton House, Gloucester, the wife of Walter Brown, M.B., of a daughter.

GREEN.—On June 16th, at Burlington Street, Chesterfield, the wife of Albert Green, M.B. Lond., of a son.

GROVE.—On June 11th, at St. Ives, Huntingdonshire, the wife of W. Reginald Grove, M.B., of a daughter.

Marriage.

STAMM—PERRY.—On June 2nd, at St. John's Church, Caterham, Louis Edward Stamm, M.D., of 18, High Road, Streatham, to Louisa Ethel, daughter of Mr. and Mrs. James Perry, of Bloomfield, Caterham Valley.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 422.] JULY 2, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	265–267
From the Gazette's Special Pathologist ...	267
The Surgery of Dilated Stomach and Movable Kidney: and their Relation to Glénard's Disease. Clinical lecture by Mr. Golding-Bird...	268–273
Case for Diagnosis	273
A Case of Post-Partum Eclampsia. Recovery	274
Change of Address	274
Correspondence	275
Diarrhœa in the Newly-Born	275
Obituary	275
The Use of the Cystoscope in the Diagnosis of Urinary Disease. By R. H. Jocelyn Swan	276–279
Testimonial to Dr. Eyre	279
Kipling Prize Competition	279
Appointments	280
Sport	281–283
Reviews	284

Passim.

ALL Guy's men will unite in a hearty chorus of congratulation of Dr. Stevenson, whose recent knighthood came as a pleasant surprise to most of us. The senior member of the Hospital School Staff, Sir Thomas Stevenson has also for many years past held the post of Analyst to the Home Office, in which capacity, by his achievements in toxicology, he has done much to bring Guy's Hospital to the fore in the public mind. As a teacher he has always been popular, ripe experience and an apparently inexhaustible fund of narrative making his Forensic Medicine lectures amongst the most interesting in the Hospital course. In that part of his work which concerns the government of this Hospital, Sir Thomas has proved a valuable member of the finance department, whilst his conscientious attendance at committee meetings, both has been and is an example to all, in a day when officialdom despairs of ever bringing the average committee-man to a proper sense of his duties.

ON the morning of June 24th, a large number of men assembled in the old chemistry theatre to welcome the newly-made knight in as enthusiastic a manner as possible. The honour conferred upon the lecturer was looked upon by most of these as somewhat unexpected, but only a few weeks previously in a certain column of the GAZETTE, about which possibly too much has already been said, we had declared that Dr. Stevenson had "done the State some service," and that "they know it." We have always thought that the Prime Minister read the GAZETTE, and in this case, although he did not send in a list as a competitor, he evidently knew to whom this referred, and we are happy to see that he took the hint.

WE should like also to congratulate Dr. Constantine Holman, another old Guy's man, who has also received the honour of knighthood.

WE owe an apology to the honorary secretary and to all the members of the Contemporaries' Club for omitting to mention in our last issue that this club is holding its annual dinner on Wednesday next, July 6th. We sincerely hope that the numbers will not suffer in consequence of our neglecting to announce the dinner. Application for tickets should be addressed to Mr. L. H. McGavin, 6, Mansfield Street, W.

FOR the benefit of any who may wish to know the inner meaning of the gorgeous colours which

will be displayed in the Park on Wednesday next, we publish the following :—

Academic Robes.

Bachelors' gowns are all black, but their hoods are as follows :—

Cambridge M.B.	Black and Pink
Durham M.B.	" " Mauve
London M.B.	" " Violet
" LL.B.	" " Blue
" B.A.	" " Brown
" B.Sc.	" " Gold
Oxford M.B.	" " Sky Blue edged with white fur
F.R.C.S. Eng.	Black and Pink
M.R.C.S. Eng.	" " Crimson

Doctors' Robes :—

London	Scarlet and violet
Brussels	" " Blue
Durham	" " Mauve
Cambridge	" " Pink
Edinburgh	" " Crimson
St. Andrews	Crimson and white satin

The Doctors' hoods match the robes.

For those who took the trouble to go down to Honor Oak Park, the annual Athletic Meeting held on Wednesday, June 22nd, was as usual a most enjoyable affair; the weather was perfect, and the sports, if not brilliant, were at any rate not conspicuously below the average. But the crowd of spectators could not be called by any means a representative one, and a great many faces that we have become accustomed to look for, year by year, were this time conspicuous by their absence. Also, it is not an encouraging sign that the vast majority of the senior men should have been presumably so busily employed elsewhere that they could not spare the time to put in an appearance. Examinations and house-appointments doubtless make great demands upon the physique, but the strain has not made itself felt to such an extent in previous years as it did at this year's meeting. Our Annual Scurry Stakes are at last to meet with that full recognition which they have always deserved at the hands of a laughter-loving public, and the cinematograph is already immortalizing the different riders and their steeds. We can vouch for it that every care has been taken to duly honour the psychological moment in as many cases as possible, and our only regret is that the veteran rider of the hospital should not have been able to once more tempt providence by giving us another exhibition of his skill in trick riding. Probably with his well known cunning he saw the camera of the cinematographist and decided to leave the honours this year to younger men.

At a Hospital dinner it is often the case that a half-hearted attempt at formality goes far towards converting a merry meeting into a funereal affair, and the Cricket Club is to be congratulated on the way it steered clear of custom and antiquity and made for merriment at all costs, so much so that in the opinion of many who were present, last Saturday evening's dinner was the most successful of its kind ever held in the college. To begin with, the President, Mr. Brailey, but for whose generosity the annual dinner would not take place, was in the chair, and throughout showed a lively interest in the proceedings. And the proceedings themselves—they beggar description. Never were there such speeches or such songs. Another happy feature of the dinner was the number of past men who were able to attend, and a suggestion made by one of these is well worthy of consideration on the part of the authorities, namely, that the Biennial Dinner might well take place on the day preceding the Past v. Present match, so that old Guy's men could, on alternate years at least, combine the latter with the former. At the cricket match the crowd of spectators is not by any means a marked feature, and the presence of a good sprinkling of past men would give the day that touch of realism which it so sorely needs.

Not the least amusing aspect of an eventful evening was the pathetically inconsequent tone adopted by more than one eminent speaker with regard to the criticisms of the cricket team which have from time to time appeared in our columns. So marked is the resentment in a great many breasts that it may be as well that the inspired source of our pessimism should be more generally known. As soon as the season commenced it seemed apparent that if we were to rely on our own slender stock of cricketing knowledge, it would only be possible for us constantly to reiterate the fact that the teams were all excellent to a degree,

that the bowling, batting, fielding, and scoring, were superlatively good, and that the cup would inevitably fall into our hands in a predestined manner. But it seemed that constant repetition of this sort of thing might not only become wearisome, but for those who knew more of the facts might even seem rather untrue, and consequently we appealed to an authority on the game that the cricket notes might be more useful than ornamental. If this same authority saw fit to be pessimistic, it is possible that there were diplomatic reasons for his so doing, and if the fact, that the present season's record is by no means discreditable, should in any way be due to his action, then the members of the Cricket Club should be the last to grumble.

A REMARKABLE apparition greeted the eyes of a Guy's man who recently looked out over the river from that convenient coign of vantage, Kew Gardens. Threading its way among the various craft of the Ranelagh Sailing Club was a neat dinghy bearing the Guy's colours in the form of a yellow anthrax bacillus on a dark blue field. The captain and crew of this remarkable boat are not so well known as their employment of the above device might lead one to think—that is to say, they are neither of them at present upon the Junior Staff, nor are they among the devoted ranks of the dealers in cultures and cocci. The captain is a bronzed sailor whose face, which resembles that of an intellectual Arab sheikh, is well known in the cricket-field, and who but recently has proved that he possesses a remarkable baritone voice. We have it on the authority of the interested spectator from the Kew bank, that, as evening fell, since the night was fine, they danced on the deck. This boat is, its crew assures us, at the head of the river, and as long as it flies its imaginative and representative pennant, so long may it remain so. Its captain desires us to give notice that on a fast-approaching date he wishes to dine the Cricket Club on board his dinghy, and that upon this eventful occasion the menu will consist entirely of bread in various forms. The dinghy is insured.

SOME exception has been taken to the article entitled "A Dining Room Dialogue," which appeared in our last issue. It has been urged in objection to this dialogue that the character of the Guy's man is absurdly overdrawn, and that by no possibility could such an abnormality have survived sufficiently long to have completed his appointments. The writer of the article is a philosopher and a man of the world, who from long contemplation of the worst virtues of the medical student, did not feel that he was altogether outraging nature in pillorying them as he did. We may state here that every objectionable characteristic portrayed is founded on fact beyond all possibility of doubt, and though the endowing of one man with all the vices of his kind may have resulted in the production of a somewhat Frankenstein monster, yet he is in no way worse than many of the originals who called him forth, and from the point of view of intellectual consistency is greatly preferable.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

H. G. A., NOTTINGHAM.—This growth is a small spindle celled sarcoma of the pelvis, and certain parts of the specimen are undergoing chondrification. There is no secondary growth in the gland.

T. M. V., BANBURY.—The sputum is non-purulent in character, and no tubercle bacilli can be found in it.

PATHOLOGIST.

The Surgery of Dilated Stomach and Movable Kidney: and their relation to Glénard's Disease.

CLINICAL LECTURE BY MR. GOLDING-BIRD.
December, 1903.

GENTLEMEN,—The subject of my last clinical lecture was Glénard's Disease, or Splanchoptosis, illustrated by a case lately in Charity ward; and whilst movable kidney, as a phase of this malady, is specially to occupy us to-day, I wish first to say a few more words about the condition of the Stomach, a matter to which I had but little time to devote on the last occasion.

The abnormal mobility of the stomach and of the kidney is especially interesting to surgeons as it is in connection with these organs that operative measures for fixation have mostly been undertaken up to the present.

I may remind you that the normal supports of the stomach are its various omenta, as the gastrohepatic, gastrophrenic and gastrosplenic. There is further its attachment to the œsophagus, whilst behind the cardia is a small area devoid of peritoneum, united by fibrous tissue to the diaphragm. Keith, in his late lectures at the College, insisted much on the value, as a support *from below, of the shelf made by the transverse* meso-colon.

We already have discussed the reasons which are believed sufficient to permit of the ptosis or prolapse of the stomach; and that condition, when established, calls for relief in some way or another, either for the actual displacement or for a secondary and more important condition which sooner or later accompanies it, and of which it may be that ptosis is the actual cause. I refer to gastric dilatation.

As far as my experience goes at present, I should say that whatever the physician may meet with in regard to a stomach merely prolapsed and not intrinsically otherwise altered, the surgeon is not likely to be consulted until a definite train of symptoms has developed, which symptoms are always due to dilatation. As a surgeon I confess I am glad that one is not early asked to operate on a ptosed stomach otherwise healthy, for it is clear that for such a condition only some method of suture to strengthen the natural points of suspension is likely to suggest itself, and the success of this, for reasons I gave at my last lecture, I do not feel very sanguine about; and I am not alone in this view. It is but fair, however, to tell you that both by putting a "pleat" horizontally in the gastrohepatic omentum (Beyea, Univ. of Pennsylvania Med. Bull., Feb., 1903), and also by actually stitching the pyloric end of the stomach to the liver, attempts in a few cases have been made to hold the stomach better in place; and entire relief from symptoms, if not absolute replacement of the organ, is claimed as the result. Time is required to show how far the surgeon may confidently trust to adventitious adhesions to support an otherwise freely hanging organ. In the case of peritoneal adhesions we know how easily they become stretched into bands even under the influence of such a weak force as the peristaltic movements of the intestines, which must be surely less than the dead weight of an unsupported stomach. It must be remembered that this treatment is proposed for patients in whom, from the nature of the case, the great supporting influence of intra-abdominal tension is admittedly very deficient.

The attempts thus to sustain the weight of the stomach have been but recently made, and we must therefore reserve ultimate judgment on this point; but the accompanying conditions of dilatation of the organ—or to speak more correctly, the methods of relieving its symptoms—we can speak more certainly about.

Do not jump to the conclusion that every *case of enlarged stomach, the symptoms attend*ant upon which you are called upon as surgeons to relieve, must of necessity be due to some pyloric obstruction. The analogy between the state of the left ventricle in a case of stenosed aortic opening, or of a urinary bladder in a case of long standing stricture and that of the stomach is not quite accurate.

The office of the two first-mentioned hollow organs is to propel a liquid against resistance; and other things being equal, an increase in that resistance is met by a corresponding muscular hypertrophy, with or without dilatation of the viscus. Propulsion is not the prime duty of the stomach; the bulk of the organ is employed merely as a churn to turn the contents about and keep up a definite circulation of them: it is the duty of the pyloric end of the stomach not only to guard the exit, as a sphincter, but also as a rubber syringe might do, to squirt the liquid chyme on into the duodenum from time to time. This part of the organ we might therefore expect to find hypertrophied, where there is some pyloro-duodenal obstruction, the rest of the organ being passively dilated by the

very bulk of the food that is delayed longer in the stomach than it ought to be; and this is just what we do find.

When the pyloric hypertrophy has reached such a pitch that it can be detected on palpation, the diagnosis of cancer of the pylorus is pretty certain to be given, especially where also dilatation of the body of the organ is evident. Do not, therefore, be too ready to come to a conclusion in these cases; and I might add, above all, do not in a case of gastric dilatation conclude that therefore there *must be* some pyloric growth, even when nothing can be felt. An idiopathic dilatation of the stomach is spoken of and described: it is, I believe, attributed to a low form of gastritis, of which chronic dyspepsia seems the chief symptom, and whether first caused or not by the decomposition of delayed food, it seems that the offensive stomach contents, occasionally vomited, might well be a cause for keeping up the septic catarrh, and thus pathologically weakening or softening the stomach walls. There is an analogy for this in one phase of the history of a urinary bladder in a case of chronic stricture; for let the patient be an oldish man, or let his health be chronically bad, and add to that cystitis—a septic process—and we know we have the data for forming a dilated rather than a compensatory hypertrophied organ. It would be interesting could we be assured that these so-called idiopathically dilated stomachs owe their inception to a mild ptosis; the relationship between these two conditions has been explained partly by a flexion in the pyloroduodenal area due to the prolapse of the organ, and partly by an interference with its blood and nervous supply through the stretching of the gastric vessels and nerves. To these may be added that when once food has begun to be unduly retained, its very dead weight will tend to increase the stomach deformity.

The surgeon must therefore always bear in mind, when consulting at the bedside of a case of gastric dilatation, that whilst in the majority of cases he may expect pyloric obstruction of malignant origin, he may be feeling what is actually a compensatory hypertrophy, and he must rely on collateral symptoms to aid him in differentiation; whilst, if he feels no tumour at all, he must not jump to the conclusion that it is there, only he cannot feel it, for a different train of events altogether may have caused the walls of the organ to yield. Glénard has pointed out a fact which is of great aid in the examination of a case, and of which I was reminded when seeing a case on Monday last with Dr. Hale White in Mary Ward; it is that in ptosed and dilated stomach there is not only an enlargement, but the lesser curvature lies lower down than normal.

In Mary lies a woman of 64 years of age, looking and declaring herself very healthy, save that for many years past she has suffered from bouts of vomiting; they may last many weeks, but when over, she is as well again as ever she was. Long intervals exist between the attacks; thus she has had two in the last three years. The vomit on these occasions is bulky; consists of semi-decomposed food, and she may be sick twice or so in the twenty-four hours; not necessarily as the immediate result of taking a meal. She has never had hæmatemesis, nor does her past history suggest ulcer or any other structural stomach condition. Her symptoms indeed point to a functional derangement. On palpation, nothing is to be made out except a stomach resonance as low as the umbilicus, but traced vertically upward it only reaches about two inches from the margins of the ribs; nothing is to be felt in the pyloric area. This does not seem a very large stomach as dilated stomachs go, but the amount of the vomit shows it can accommodate much more than it ought.

Now this case was sent up as one of pyloric stenosis from some cause, and operation for its relief was wished for; hence my concern in the case.

Now, neither Dr. Hale White nor I can say whether there is or is not a pyloric growth; but the consideration of two or three circumstances made me venture the opinion that there might be no growth at all. These were the circumstances: the history of the vomiting extends over many years, the intervals between the bouts are very long, though the attacks when they come try her to the utmost; the upper edge of the stomach, as far as can be determined by percussion, is not as high as it ought to be, yet it has an abnormal capacity; thus suggesting an organ that is dilated, but at the same time moved down from its normal position: lastly, the abdominal walls are flaccid and suggestive of decreased intra-abdominal tension. Under these circumstances I have ventured to think we have a case of ptosis of the stomach, with dilatation, to deal with; at any rate there is as much justification for this view as there is for that of pyloric growth.

The occurrence of dilatation without evidence of pyloric growth, will be further impressed on your minds if I tell you of a case we had only last week at one of the Public Examinations. A patient presented himself for the clinical examination with the diagnosis of an enlarged stomach. He was a spare six-foot man, about fifty-five,

with rather a gaunt and drawn face, suggestive of prematurely wasted tissues. When he lay down all the signs of percussion, succussion, etc., of dilated stomach were present, and through his lax abdominal walls the bulk of the stomach could be seen. His chief trouble was periodic, and consisted in excessive vomiting of decomposing stomach contents. The amount brought up seemed to be excessive, if his own statement was correct. In reply to the question of pain, he said he never had any, only the dead weight of fulness, but that that day he was very comfortable having in the morning vomited two "chamberfuls" of offensive contents. A thorough examination of the abdomen failed to discover any pyloric pain or thickening, and when we made him stand his outline was very peculiar; for from his sternum to his umbilicus he was absolutely flat and then bulged out into the most perfect pot-belly you can imagine.

I do not think there was any doubt as to his case being one of Glénard's disease, yet I am sorry to say, out of a large number of candidates for the examination, who wrote upon the case, only one made a correct diagnosis; one or two assumed a fibrous or cicatricial pyloric contraction, and the rest said there must be a pyloric growth though it could not be felt.

It is no breach of confidence to let you thus far into the "secrets of the prison house"; I have done so that you may remove from your minds the idea that because a stomach is dilated it must therefore be materially obstructed at the pylorus, whether you can feel it or not.

Without thus trying to clear first the pathological atmosphere that surrounds these cases, I could not speak to you of their surgical treatment, but now I think we can do so on scientific and practical lines.

Where an enlarged and ptosed stomach is part only of a general splanchnoptosis, as in the case I read to you last lecture, it is clear that even if you adopt the plan of putting a reef in the natural fibro-serous supports of the organ, it will not suffice without your doing something to increase the intra-abdominal tension whereby the organ is lifted from below; and if the latter is properly carried out I think you will find that stitching up the stomach will not be, or will very seldom be, required. A properly made abdominal belt will be your patient's best friend after all.

You will, however, say that the symptoms do not seem to proceed so much from the organ having prolapsed, as from the condition of dilatation it is in; cannot this be relieved? This has been attempted, and in 1900 Mr. Mayo Robson published the account of twenty-eight cases where he had performed what is known as gastro-plication. Some of his, however, were cases where there was actual pyloric obstruction, and with these we are not dealing; but this operation, with or without the strengthening of the stomach-supports in the way above mentioned, would seem to offer a prospect of relief for the symptoms which distress these cases.

As I can point out a more certain method of relief I will only add, about gastroplication, that it consists in involuting a fold of the stomach wall, and then running a seam of Lembert sutures to keep it thus turned; in this way the organ is diminished in size.

You will at once see the weakness of the treatment. You want either to drain the stomach of the food taken, yet leave the food to be still of use to the patient, or give such strength to the organ that it can pass the food more readily into the duodenum. Neither of these will gastroplication fulfil, and it fails therefore in primary essentials.

I can tell you of no surgical means of increasing the muscle power of these stomachs, but I can tell you of an admirable way of draining them physiologically.

We are learning almost daily the great value of this physiological drain; its effect is not merely mechanical, it is functional, and thus all in the direction of benefit to the patient.

Originally designed and practiced to obviate starvation and to feed a patient with obstructed pylorus, we know now that gastro-jejunostomy, and especially in its posterior (von Hacker) form, is one of the most valuable aids the surgeon possesses in many stomach conditions.

It thus is not only the ideal method of dealing with inoperable pyloric obstructions, but by quickly and without effort allowing the food to pass into the small intestine, unhealthy states of the stomach wall, kept up, if not induced by the failure of the organ to do its proper work, begin to improve; and cases even of such conditions as acute gastric ulcer recover, without any other interference with the ulcers themselves. Indeed it is now advanced as the best way of treating acute gastric hæmorrhages. It certainly fulfils a condition always interesting to Guy's men, since it was taught and insisted upon by John Hilton (in speaking of other parts of the body), for it gives what that great surgeon called "physiological rest to the inflamed and weakened organ."

Lastly, in a "Glénard" stomach such as we have been studying, whilst it will not relieve the

ptosis nor give power to the organ, this operation removes rapidly from its cavity the food that otherwise stays there to decompose and gives rise to all the patient's symptoms, and passes it on to the intestines for his nourishment and to his undying comfort and satisfaction.

Of the operation details I can say nothing at this lecture, it must suffice only to add that it consists in sewing a piece of jejunum to the posterior wall (the anterior is not so good) of the stomach, which has been brought through a vertical opening torn through the transverse meso-colon, the colon being raised up and out of the way in the meanwhile. The junction may be effected by a Murphy's button or one of the forms of bobbin; but suture, pure and simple, is after all the best in practised hands.

Renal Ptosis.

The case of the woman, who had general splanchnoptosis and who was the subject of my lecture last week, gave us an example not only of ptosis of the strictly intra-abdominal or pendulous organs—as liver, stomach, &c.—but of the more fixed non-pendulous, post-peritoneal organ, the kidney. The contrast between these two groups of organs from the clinician's point of view, I have already discussed, and I have pointed out to you the means by which the kidney is normally retained *in situ*. Further, I ventured to throw considerable doubt upon the view that the neuro-vascular "pedicle" of the kidney takes any share in helping to fix it, though I allowed it would limit its excursion in a circular sense, when once displaced, and that the drag thus put upon the vessels and nerves might be the cause of both local and referred pains.

Glénard himself attributes what I here call referred pains, *i.e.*, gastric pain, vomiting, etc., not to reflex irritation from the kidney, but, in all renal ptosis cases, to the fact that there is besides a ptosis of other organs: in fact that all movable kidneys are so by virtue of their being sharers in a general splanchnoptosis.

Surgeons certainly cannot endorse this: for they constantly are called on to treat cases of movable kidney where no other organ can be discovered to be misplaced.

I am willing to admit that where, besides the dragging loin pain and backache so characteristic of a movable kidney, there are symptoms, as dyspepsia and vomiting, referable to other organs, it is well to most carefully examine and see if the stomach is involved in the manner I have already explained; though the presence of these symptoms no more confirms the view necessarily of a general abdominal ptosis, than does their absence show that such a physical condition is entirely absent.

We have a case now in Charity ward in which vomiting accompanied a movable kidney; I was at a loss to know what value to put on that symptom, since it might either have been due to the kidney (which I have now fixed in its place), or to a condition of stomach following a gastric ulcer from which the patient suffered nearly four years ago. Local lumbar pain seemed to be due to the kidney, hence the treatment; but only after the patient has been up and about again can I speak of its value in stopping the sickness. Here at least is a case in which the vomiting is certainly not due to gastroptosis.

The following case is a clear one of movable kidney, due solely to injury, a predisposing cause that the report reveals being granted; no other organ was displaced.

Miss S., æt. 28, a governess, strong, well-built and healthy, who had passed all her life in the country, two years before I saw her had begun to take what was even for her, undue exercise, for she added to her amusements the sport of following the foxhounds on foot. This soon began to tell upon her; her friends remarked that she was getting thin, though she herself felt in perfect health. Six or seven weeks before I saw her, in one of her runs, she suddenly lifted over a stile a boy who was accompanying her; she immediately felt "something give" in the left loin, and suffered from severe pain. She, however, walked home and was about for a day or two, but from that time has had to give up exercise, and has become semi-invalided, on account of an aching in the left lumbar region, extending across the back at times, and accompanied with tenderness in front, a little below the ribs. Movement always aggravates her pain.

She consulted me believing she had spinal disease. I eliminated all question of spinal trouble, and from her symptoms, as well as from the fact that I could clasp the lower lobe of the left kidney in my two hands, I came to the conclusion it was a case of traumatically ptosed or prolapsed kidney. I could easily cause the organ to slide up and back to its normal bed, then I lost touch with it. (Glénard strongly insists that if the examining hand feels any part of the kidney whatever the organ must be ptosed little or much, and I believe my medical colleagues would say that quite a normal kidney should not be felt; but for the surgeon's purposes the way the organ slides from the grasp of the hand, thus proving its

mobility, is of more value than the mere fact that he can feel it. Cases such as this quite explain the phantom tumours of a passed generation.)

This is really an interesting case as it illustrates the positive way in which a movable kidney may be caused, and demonstrates that this may happen in a healthy young woman in whom there did not exist one single condition either productive of, or indicative of, a general splanchnoptosis.

You observe she had for two years been getting thinner; I do not say *losing* flesh, lest I should suggest a wasted cachectic person, but simply *lost* from excessive exercise all superabundance of adipose tissue. Thus she starved the fatty capsule of the kidney and left it to the mercy of the first severe strain, and this occurred five weeks before I saw her in the way I have mentioned.

Torn from its fibrous surroundings it had slipped down behind the peritoneum, its excursion being limited by the renal vessels and nerves, and hence the pain complained of.

Such a case as this, one could not claim as one of splanchnoptosis; the kidney alone was the subject of displacement, the outcome of an overstrain; and many of these cases of movable kidney you see in comparatively young women in the hospital or outside, are of this class, and present no other signs of displaced organs.

Vomiting in renal calculus we are all very familiar with, and a tender movable kidney can excite the same train of symptoms; this occurs through its connection with the splanchnic nerve distribution overlapping that of the stomach; and by the union of the same nerves with the anterior dorsal cerebro-spinal nerves, the dull aching pain all round the umbilicus is explained at the same time.

The term "floating" kidney which I have till now avoided, needs a remark. The very movable kidneys one sees now and then are thus called, and their explanation is that they possess a meso-nephros or true mesentery of their own. As far as I can discover no one yet has demonstrated this condition. I have never seen it, and I may as well tell you at once, that at present I am not satisfied as to its existence.

The kidney in its movements is freely playing behind the peritoneum which may even be so stretched as to allow of the organ really to float to the surface of the abdomen; but it is only by virtue of a detached peritoneum and not of a congenital condition or meso-nephros.

As in the case of the stomach, so in the kidney a distension of the organ may occur as the result of its mobility, but the explanation is not the same in both cases; for in the kidney it is always the result of some kink or bend or block whereby the outflow of the urine is impeded.

This is one way in which the familiar condition known as hydronephrosis is brought about; and whenever you meet with it remember its possible connection with a movable organ.

The treatment of ptosed kidney is now well agreed upon. Years ago these cases were either dubbed hysteria or phantom tumour; and no relief being then afforded them, they enlarged the ranks of chronic invalids. Then came a period of reaction—and of action! headed by the late Mr. Durham, who on an occasion I shall never forget, May 14th, 1872, removed the kidney from a woman who had been repeatedly in the hospital in the medical wards for renal pain, and had been regarded as hysterical. Finally it was agreed, when she was admitted into Lydia, then the ward of Dr. Owen Rees, that she should have the kidney removed, it being now believed that a stone must be after all the bottom of her suffering. Mr. Durham, then for the first time in this country, performed nephrectomy. Though unfortunately the woman succumbed to shock, the interest in her case was very great; nor was the operation undertaken without repeated consultations. I recollect about nine at night our being surprised by a visit from Sir William Gull, whom Mr. Durham had consulted on the question of operative treatment.

To Kahn, of Berlin, who in 1881 introduced nephrorrhaphy, do we owe our present practice in these cases, and the methods by which we fix the kidney may be divided into two. In one the true capsule is stripped off the convexity of the organ, after its exposure through a lumbar incision, with the double object of exposing a raw surface to unite to the parietes, and of yielding two fibrous "ligaments" whereby it may be fixed; this is the method of Tuffier (Paris, 1889). The other does not interfere with the kidney structure, but suitable sutures of silk, gut, or tendon are passed actually through the kidney substance, and then through the muscular and fascial parietes and tied. This method is advocated by Henry Morris; it is the one I myself have mostly employed.

In both—as indeed in any method, for there are others—the object to be attained is the fixing, by permanent adhesions, of the kidney again in its socket, even more intimately to the posterior abdominal wall than it was naturally; and the patient is thus relieved of present

symptoms, as well as of the fear of future hydronephrosis; and the result is most successful. It may seem contradictory that I advocate this method of adventitious adhesions now, whilst I throw doubts as to its value to fix the stomach. The reply is easy. In the case of the stomach a pendulous dead weight always will be dragging on the new adhesions; but in the kidney there is no question of drag, and of but little strain, on account of its anatomical position and relations. Unless associated with a general splanchnoptosis, the operative results are most satisfactory.

The other day I had occasion to remove the kidney of a young woman that the late Mr. Davies-Colley had sewn down seven years ago; the amount of fibrous tissue around it and the firmness with which it was held would clearly have resisted any attempt to push it from its artifically formed connections.

Lastly, where a movable kidney is part of a general splanchnoptosis, the question has not infrequently been asked me, Is it well to perform nephrorrhaphy? The answer is, I think, easy. For the general conditions, support as before-mentioned should at once be tried; if then the loin pain continues the kidney may certainly be sewn in its place, for this reason, that belts of various forms will generally suffice to induce enough intra-abdominal tension that the various intra-abdominal and pendulous organs are relieved of painful strain; but the kidneys, small in size, and lying right behind, are by no means so readily affected by such general pressure, but if fixed by the surgeon, then the additional use of the belt will probably restore the patient to usefulness and entire comfort once more.

Pass List.

University of Cambridge, June, 1904.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

PART I.—L. G. Davies, E. C. Hughes.

University of Oxford, June, 1904.

DEGREE OF DOCTOR OF MEDICINE.

A. E. Boycott.

Case for Diagnosis.

CHOSEN FOR COMMENTARY IN EXAMINATION FOR TREASURER'S GOLD MEDAL.

A LIEUTENANT in the army, aged 25, enjoyed perfect health until he went to India on duty. His father died at the age of 50 from double pneumonia. His mother and her four other children were strong and well. In his first year of residence in India he had a slight attack of "fever." In his second year, seven months before his death, his fatal illness commenced. The first symptoms were abdominal pain, vomiting and diarrhœa. He is confident that the motions did not at this time contain blood. He was treated for worms, but none were found, nor were his symptoms materially relieved when, a month after the commencement of his illness, he was sent to the hills. Here he came under observation by another set of medical men, who suspected gall-stones on account of the frequent paroxysmal pain from which he suffered. He did not become jaundiced, but lost much flesh, and in the third month of his illness he was invalided home, his certificate being signed "biliary colic."

During the first month in England the patient was kept in bed, on slops, and his attacks of pain were lessened, but the bowels were very troublesome, being sometimes constipated and at others relaxed, and when relaxed the motions contained much mucus. The pain, though less severe, persisted, and the patient thought it was made worse by taking food.

On examination of the abdomen no swelling could be found, nor any local tenderness. During manipulation occasional spasms of pain would occur, referred by the patient to the umbilical region. At the moment of pain some slight increased resistance or rigidity was noticed in the right inguinal region, and some gurgling was felt or heard. Nothing could be made out by rectal examination.

At this time the patient, who was six feet high, weighed 9 stone 7 pounds, having lost two stone since the beginning of his illness.

He was now allowed to get up and go about, his diet being strictly regulated, much against his will. Three weeks later, after some indiscretion in food, he passed a considerable quantity of blood with his bowels, and this was repeated on several subsequent occasions.

After this a consultation was held with a surgeon, but it was decided that no operative interference was desirable. The patient remained in much the same condition, and it being found impossible to properly regulate his diet, he was admitted into a nursing home. He was put on milk diet, and becoming rather constipated an aperient was administered. Shortly afterwards such urgent abdominal symptoms supervened that it was thought necessary to perform laparotomy. The patient died from empyema a month later.

For Solution see p 284.

A Case of Post-Partum Eclampsia—Recovery.

ALICE H., æt. 22, unipara, was admitted into Victoria ward under Dr. Horrocks on May 25th, in a comatose condition, having been delivered of a full-time live child fifteen hours previously.

She had a history of fits in early childhood which prevented her going to school.

Menstruation commenced at thirteen, and she had a full-time live child when she was seventeen, with a normal puerperium. No pregnancies since till the present one. During the last two months of "carrying" she had dropsy of the legs, loins, and face, and suffered a good deal from headache; her friends noticed she was rather thick in speech and drowsy, but she did not consult a doctor.

Labour was easy and rapid, and terminated at 2 a.m. on May 25th; it was noticed at the time that there was some anasarca—she passed a restless night and rambled a good deal in her speech. At 3 p.m., thirteen hours after delivery, she had a fit, which was followed by a series of fits with intervening coma until admission at 6 p.m.

On admission, the temperature was 101° and the pulse very rapid and small; patient was quite comatose and there was considerable anasarca and dryness of the skin; about ʒvi. of urine were drawn off from the bladder though a catheter had been passed less than three hours previously on the district; the urine was loaded with albumen but contained no blood or casts.

It was found necessary to keep the patient anæsthetised more or less continuously till 9 p.m., as fits recurred as soon as she came round. Four pints of saline fluid were injected into the cellular tissue and calomel was given in butter. At 9 p.m. a hot air bath was given with very good effect, causing free sweating, but also producing a waterlogged condition of the lungs and much cyanosis and respiratory difficulty in consequence. At ten o'clock a fair quantity of urine was again drawn off and found to contain 14 parts per thousand of albumen of which 2·6 were serum globulin, and 11·4 serum albumen. The urea measured 1 per cent. Patient had no more fits but remained drowsy and irritable throughout the night; the larynx got stuffed with mucus and had to be frequently cleared out with swabs on sticks. Oxygen inhalations gave little relief and propping up in bed had no effect; the cyanosis became extreme at 10 a.m. on the 26th, and was much relieved by venesection, ʒviii. of blood being let.

The bowels were very obstinate and did not yield to calomel and croton oil till an enema had been given late in the afternoon. Patient remained semiconscious all day and sweated freely; she passed a fair quantity of urine under her; the temperature remained between 100°–101°. Her pulse was very rapid and weak and strychnine was given hypodermically ɱiv. 4tis. horis. The eyes were examined for retinal hæmorrhages with a negative result. The respiratory condition was much improved. On the 27th she was better and evinced some interest in her surroundings, enquiring after her baby. She took fluids *ad lib.* and passed ʒxx. of urine during the day. The albuminuria diminished to 1·5 parts per 1000, of which one part was serum albumen and half serum globulin. The excretion of urea bounded up from 1 per cent. to 2·8 per cent.; œdema is still present though less marked. Temperature 101°–100°. On the 28th the temperature fell within a few hours to 98°, and patient appeared in every way brighter and better. Some hemiparesis of the left side was noted; the urine only contained a trace of albumen.

From this date the patient got better daily, though a trace of albumen persists up to date; the œdema has all disappeared and the hemiparesis recovered in two or three days. She never had any milk with which to suckle the baby, which, however, thrived on artificial feeding.

I have recorded this case on account of its extreme rarity, as I can only find four other cases of post-partum eclampsia among the reports for the last five years. Two of these were mild cases which showed no symptoms of interest; one was very severe, with hyperpyrexia and death in three and a half days from her confinement, and one very closely simulated the case above related. All the previous cases occurred in young primiparæ, and their severity seems to vary directly with the length of time between delivery and the first fit. In the fatal case twenty-four hours elapsed, and in the two mild cases twenty minutes and one hour respectively; in the other case four hours separated the confinement and the first fit. Severe headache during the last weeks of pregnancy occurred in all the cases and I think is an important premonitory symptom of eclampsia. A previous history of fits was not found in these four cases. The amount of urine being secreted has also an important bearing on the prognosis, and the moderate amount passed by the subject of this paper was the only hopeful feature in her case during the first twenty-four hours.

I am indebted to Dr. Horrocks for permission to publish this case.

C. H. REINHOLD.

Change of Address.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Dr. John Evans, from Guy's Hospital to Shorehitch Infirmary, N.

Dr. F. A. Godson, from Cheedle Hulme to Westbrook, Central Road, Withington, Manchester.

A. E. D. Prideaux, L.D.S., from Guy's Hospital to Ermington, Dorchester.

We regret to learn that Dr. Ham, Commissioner for Public Health, Queensland, has resigned his appointment, presumably, as a protest against the retrenchment proposals of the Government. We hope that Dr. Ham's services will not be lost to Queensland.—*The Australasian Medical Gazette* for May, 1904.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

SIR,—I have recently come into possession of the 1650 edition of T. Venner's works. He was a physician at Bath. It is an interesting little book on Bath waters, and whilst telling the reader how to live a long and healthy life, Venner indulges in a violent diatribe against tobacco. What makes this copy the more interesting is that it belonged to Thomas Lambarde, grandson of the Kentish historian and editor of several of his works. On the fly-leaf, under his name, with date 1669, he has written—

Phisica est ars bene medendi,

And below this libel on the profession—

Est medicinalis Medicorum Regula talis
Ut dicant, da, da, dum dicit Languidus, Ah! Ah!

The Doctor's practice is to aske for gayne
Even at ye time when men cry out for payne.

Thomas Lambarde was squeezed during the Commonwealth. He was given to writing such-like quotations in his books.—Yours truly,

F. WILLIAM COCK.

Diarrhoea in the Newly Born

I SHOULD be glad if any of your readers would tell me how to treat any future case similar to the following :—

Mrs. J. J., the wife of a policeman, had a child born in April, 1902. She reports that the child wasted from birth and died of diarrhœa on the 19th day.

In July, 1903, she took charge of a foster-child of a fortnight old. This child was fed first on diluted cow's milk, next on condensed milk, and finally on Allenbury No. 1. It slowly began to fade away, and after three months died of marasmus.

On April 10th, 1904, I was summoned, and found very feeble pains, with an os the size of a shilling. No treatment was needed. On April 16th the child was born without much difficulty—presentation L.O.A. The child was small, but appeared to be quite healthy. The mother was about twenty years old, and looked like a "white woman with a white kidney;" but her looks belied her.

Next day—that is within twenty-four hours of birth—the child was passing stools containing blood and mucus quite typical of acute ileo-colitis. Up to this time the breast had been taken twice. Very small doses of Ol. Ricini were given. Next day the blood had stopped, but in the twenty-four hours there had been thirteen motions, a number similar to the day previous.

Despite all treatment the diarrhœa continued, and for the next week the motions were sixteen, fifteen, seventeen, sixteen, eighteen, seventeen, seventeen. During the last three of these days the bowel was washed out twice daily with warm water. On April 27th mss. tinct. opii. was given—a large dose, but heroic measures were needed. The motions dropped to ten, but the child was very drowsy for about fifteen hours. A sample of the mother's milk showed very poor percentage of cream, and Allenbury No. 1 was given instead. There was no improvement, the child gradually wasted, the bowels were open eight or nine times in every twenty-four hours, and death from inanition occurred on May 15th, twenty-nine days after birth. For the last four days the liver was on a level with the umbilicus, and there was extreme abdominal distension.

Remarks.—The parents denied syphilis, and there was positively no reason for suspecting that disease. No cause could be found to account for the diarrhœa or blood. No post-mortem was permitted. The feeding was regulated and every care taken of both mother and child. Cream was given to supply the deficiency in the mother's milk. No treatment appeared to have the least beneficial effect. In this case, at any rate, the oft-blamed cow's milk and hand-feeding was not at fault. The easy labour does not seem to indicate any internal injury.

R. C. M.

Obituary.

Robert Charles Basker Shaw.

It is with deep regret that we record the death, at the early age of 24 years, of Mr. R. C. B. Shaw.

He died after a short illness from tubercular disease at his home at Swineshead, in Lincolnshire, on Tuesday, June 21st, 1904.

Educated at Sedgebrook School, passing the matriculation examination of the London University in June, 1899, he intended becoming a schoolmaster, but subsequently resolved to adopt the profession of dentistry.

He became the private pupil of Mr. H. L. Pillin, and entering Guy's in Oct., 1903, he carried off the Entrance Scholarship in Dental Mechanics. His industry also gained for him the First Year's Proficiency Prize in the Dental School, the award being made known to him a few days before he left London at about the middle of last month. It is an open secret that his marks in this examination were very high, indeed one of the senior members of the Dental Staff said, "Shaw's percentage of marks in my subject was relatively higher than any I remember for the past ten years."

Undoubtedly, if his life had been spared his exceptional ability would have won for him the highest position in the school, and in the dental profession.

Possessed of genial manners, he was a great favourite, and one who will be much missed by his fellow students.

The funeral took place at Swineshead on Friday, June 24th, amidst every manifestation of general mourning.

We respectfully offer to his parents our heartfelt sympathy in their bereavement, and desire at the same time to express to them our high appreciation of their son's worth, and the loss that his death has caused to Guy's.

The use of the Cystoscope in the Diagnosis of Urinary Disease.

BY R. H. JOCELYN SWAN, M.S. Lond., F.R.C.S.

So many times have I been questioned upon the value of the cystoscope in the diagnosis of urinary disease during recent months, that I have been tempted to occupy a short space in the GAZETTE with a few impressions that I have gleaned whilst engaged in urinary work. Although the cystoscope has now been in use for some years the interest taken in it by the majority of surgeons is very slight, usually owing to a mistaken dea of its capabilities. This is probably due to the fact that it takes some considerable time to learn the use of the instrument, as is the case with the ophthalmoscope, not so much in the difficulty in gaining a satisfactory view of the interior of the bladder, as from the necessity of gaining sufficient experience to appreciate the various changes observed either in the bladder wall or in the ureteric orifices. A further argument brought against the use of the instrument, namely, the dangers of its introduction into the bladder, is practically negligible, for there is no more danger in its use than in the passage of an ordinary metal sound through the urethra, provided of course that the operator uses that care in his asepsis that is expected of him in the present day. Further than this the instrument can be used without submitting the patient to a general anæsthetic, all that is required being an injection of cocaine into the posterior urethra before any manipulation is begun. The remaining objection, that bleeding would obscure the cystoscopic view, can usually be circumvented by gentleness in the use of the instrument or by irrigation of the bladder by a weak astringent lotion, such as adrenaline chloride 1—8000, or silver nitrate 1—10000.

By the use of the cystoscope many patients can be saved from exploratory operations upon either the kidney or bladder, and the few cases which are given below will, I think, amply justify the use of the instrument and call loudly for a more extended examination by its means in the practice of operating surgeons. Cases which from their symptoms have been diagnosed as renal disorders, are found to be due to abnormal vesical conditions, whilst, on the contrary, many suspected vesical cases turn out on cystoscopy to be due to renal causes. The cystoscopic examination comprises not only a thorough view of the vesical walls, but also a comparison of the two ureteric orifices, with the nature of the urine expelled from them, and this will often prove the deciding point in the diagnosis of an obscure case.

The method adopted for cystoscopic examination of the bladder is as follows:—The external urinary meatus being well cleaned with lysol solution, the urethra is cocainised (unless a general anæsthetic is given) with a 10 per cent. solution of cocaine by means of a Guyon's syringe passed down to the prostatic urethra; a soft catheter is then passed and the bladder washed out with boracic lotion until a clear medium is obtained, when the bladder is distended with eight to ten ounces of boracic lotion and the cystoscope introduced. Lubrication of the various instruments used is effected by glycerine, as oil renders the view hazy by forming a film over the window of the cystoscope. The buttocks of the patient are raised on a small pillow, this small manœuvre throwing the base of the bladder better into view. The whole surface of the vesical mucous membrane can thereby be systematically brought into view by rotating the cystoscopic tube, and finally each ureteric orifice can be examined and note taken, not only of the character of the urine expelled from each side, but the rate of flow and the force of ejection from each orifice.

CASE 1.—Obstruction to micturition by a small vesical papilloma. Complete catheter-life for four months. Removal of growth followed by normal micturition.

J. P., æt. 54. Admitted for inability to pass urine except by catheter.

History.—Two years ago there commenced an increased frequency of micturition and on three occasions subsequently blood was noticed in the urine. In September, 1903 his frequency amounted to hourly both by day and night, and a month later he had acute retention, when he was admitted to St. Mary's Hospital. He remained in the hospital for a month on complete catheter-life, and has since that time been entirely dependent upon his catheter, passing it easily at three-hourly intervals. No cystoscopic examination was made in St. Mary's. In January, 1904, he came to St. Peter's Hospital, when on examination no stricture was found, nor was the prostate enlarged into the rectum. No increased resistance could be felt in the bladder base, nor any enlarged pelvic glands. Urine was turbid, sp. gr. 1012, acid, pus and albumen present No blood nor casts found.

Cystoscopy showed a small, coarsely fimbriated, pedunculated papilloma, springing from the bladder mucous membrane to the left of, and immediately above the internal urethral orifice, which no doubt blocked the channel and prevented natural micturition. The growth was removed by suprapubic cystotomy, and he commenced passing urine per urethram within fourteen days of the operation. He now passes urine freely and without difficulty at normal frequency.

This patient had apparently been condemned to catheter-life on the supposition that he had an intravesical prostatic enlargement. No cystoscopic examination had been made, and without this it would have been difficult to arrive at a true diagnosis.

CASE 2. — Suprarenal endothelioma invading renal pelvis. Nephrectomy.

H. B., æt. 53. First seen in December, 1903, for profuse hæmaturia.

He was perfectly well until July, 1903, when he first noticed a sharp pain in the back across the lower lumbar region, more particularly on the right side. The pain lasted four hours, causing sweating and retching, but was not followed by hæmaturia. A similar attack

occurred in August, and a month later patient was surprised to find the urine loaded with blood on passing it, without any previous pain or discomfort. The hæmaturia continued intermittently after this, sometimes accompanied by the passage of rounded clots which on one occasion caused retention by blocking the urethra, whilst at other times the urine was clear for a few days and then the bleeding reappeared, but he had been absolutely free from pain since August.

Cystoscopy.—Blood was seen issuing in jets from the right ureteric meatus, but on pressure being made over the right kidney all efflux from the right orifice ceased. The left ureteric orifice was normal and clear urine flowed from it. The bladder wall was normal.

Neither kidney could be felt and no tenderness on either side was noted on deep palpation in renal area.

A diagnosis of right renal growth was made, and two days later the right kidney was exposed by the lumbar incision and the upper pole found invaded by growth. Nephrectomy was performed, and on dividing the kidney vertically the growth was found to have invaded, and to be projecting into the renal pelvis. Microscopically, it proved to be an endothelioma probably arising from an accessory suprarenal rest on the renal cortex. Patient made an uninterrupted recovery and when last seen on June 24th was quite well.

In this case not only was the source of the hæmorrhage found to be in the kidney, but the side affected was shown by cystoscopic examination, enabling us to remove the growth in an early stage and thus give the patient an excellent chance of complete recovery. Previous to the cystoscopy it was difficult to determine either of these essential points.

CASE 3.—Vesical papilloma at ureteric orifice; symptoms simulating renal growth.

Mrs. R. G., æt. 30. Admitted for hæmaturia and gave the following history:—

She first noticed a dull aching pain in left costo-vertebral angle two years ago. The pain being constantly present marked by occasional attacks of more severe pain passing through from the back to left umbilical region, but not passing into the groin or leg. Some six months later she first noticed hæmaturia, the urine being deeply tinted with red blood, intimately mixed and without clots. This persisted for about ten days and then the urine was again clear for a time, but frequently during the following months she found the urine blood-stained. Six months ago she had another severe attack of hæmaturia and this had remained more or less constant until she came under observation in April last. The lumbar pain bore no reference to the amount of the blood in the urine, but had become more severe during the later months. She was pale and anæmic from the continued bleeding. On examination the left kidney could be felt to descend on inspiration, and was tender to palpation, but did not seem to be enlarged; the right kidney could not be felt.

On cystoscopy, a smooth surfaced pedunculated papilloma could be seen springing from the vesical mucous membrane immediately to the left of the left ureteric meatus, the tumour obscuring the orifice from view, although the swivel of the urinary efflux could be seen on inner side of the growth. The remainder of bladder-wall was healthy. The growth could not be felt per vaginam. The growth was removed on April 8th by suprapubic cystotomy, but so close was the pedicle to the ureteric meatus that the vesical mucous membrane around the base could not be entirely removed for fear of subsequent contraction of the orifice. Patient left the hospital well on May 2nd, having lost all her renal pain.

This case exemplifies the importance of cystoscopic examination, for here the renal pain was undoubtedly due to the drag of the growth upon the ureteric meatus. The combination of renal pain and hæmaturia favoured a diagnosis of renal growth, until cystoscopy showed the true nature of the trouble.

CASE 4.—Vesical tuberculosis: symptoms simulating calculus.

H. B., æt. 24. *Family history: no tubercle in family.*

Patient was quite well until three months ago when he first noticed blood in the urine, with increased frequency of micturition amounting to hourly during the day though none at night. The hæmaturia persisted for a week, but after this did not reappear until a fortnight ago, although during the interval patient was still troubled with increased frequency of micturition and the urine was turbid. Two weeks ago he again noticed blood in the urine, occurring at the end of micturition and accompanied by sharp pain in the glans penis "as if he wanted to squeeze more out." He also had perineal pain on exercise or jolting in an omnibus. The kidneys could not be felt, and the testes and epididymis, prostate and vesiculæ seminales, were found normal.

Urine was alkaline, turbid and pale. Sp. gr. 1012, albumen and phosphates in excess were present, and under the microscope a centrifugal deposit contained triple phosphate crystals, blood, pus, and numerous tubercle bacilli.

Cystoscopy.—Right ureteric orifice was large and raised on a congested area of mucous membrane. Surrounding the orifice was a ring of raised submucous tubercles, one of which, just below the orifice, had broken down into a small crateriform ulcer. Above and to the right of this orifice was another congested area containing raised tubercles in various stages, some of which had broken down, leaving a ragged ulcerated surface. The left ureteric orifice was normal and clear urine was ejected from both. The bladder-wall was sacculated.

The cystoscopy was performed under cocaine anæsthesia of the urethra, and a vesical distension of ten ounces allowed without pain or discomfort.

The absence of nocturnal micturition and the easy distension of the bladder in this case are unusual with tuberculosis. The case was thought to be one of calculus, but the true diagnosis was arrived at by the cystoscope, and confirmed by the finding of the bacilli under the microscope, thus preventing any further interference which is often so disastrous in these cases.

CASE 5. — Calculus impacted at ureteric meatus. Pyonephrosis.

Mrs. E. R., æt. 46. Admitted for tumour in right hypochondrium.

Sixteen years ago patient had severe pain in right lumbar region lasting for four days, causing retching and prostration, and at end of this time a small, irregular calculus was passed per urethram. She remained well until two years ago, when she again had pain, commencing in the right lumbar region and passing into the groin of same side, similar attacks occurring at intervals of about six months. During the last two months the attacks have occurred much more frequently and the urine has been found dark ("chocolate-coloured") after the pain has ceased. She has also been jaundiced on two occasions, in one of which the jaundice and pain were both present at the same time. Patient is a stout woman, and on abdominal examination a rounded mass can be felt in the right hypochondrium, reaching from the right costal margin to the level of the umbilicus; it moves slightly with respiration, the percussion note over it is dull and it can apparently be grasped bimanually with one hand in the loin, but patient is so stout and keeps the abdominal muscles so rigid that examination is difficult.

Urine: Acid. Sp. gr. 1018, turbid with thick, greyish deposit.

Albumen was present and numerous pus corpuscles seen under microscope. No blood present.

Cystoscopy.—A small, conical, black, irregular calculus was seen projecting from the right ureteric orifice, projecting into the field from a nipple-shaped mound, at the summit of which was the dilated orifice. The left ureteric orifice was normal. The calculus could be felt per vaginam and on bimanual examination it was manipulated from the ureter into the bladder. On again passing a catheter, foul, greenish, purulent fluid was drawn off, and after washing out the bladder with boracic lotion and again cystoscoping, the calculus was found lying free in the bladder, whilst the right ureteric orifice was patulous and from it a dense jet of greenish pus was made to flow by any pressure on the abdominal tumour. The calculus was easily extracted by an evacuating canula and the abdominal swelling emptied by gentle pressure, the contained pus escaping by the now patent ureter and washed out from the bladder by irrigation with boracic lotion. Finally the tumour became quite flaccid and collapsed.

The bladder was washed out daily and patient left the hospital a fortnight later absolutely free from pain and the urine only containing a very small amount of pus. The right kidney could still be felt on bimanual examination, but only slightly enlarged.

This patient did not present the usual symptoms given when a calculus is impacted in the terminal inch of the ureter, further than this it was difficult to determine the exact nature of the abdominal swelling. Had a simple nephrotomy been performed to drain the pyonephrotic kidney, a urinary fistula would probably have resulted owing to the impaction at the ureteric orifice, but any cutting operation was in this case found unnecessary after the obstruction had been removed by simple digital manipulation.

CASE 6.—Impacted ureteric calculus.

H. W., æt. 35.—Patient had nephrotomy performed on him in Guy's in 1901 for supposed left renal stone, but none was found. He had had lumbar pain and hæmaturia for about a year before the operation.

Two months after the operation, on recommencing his work, he again had pain, but then felt at a spot midway between the umbilicus and left anterior superior iliac spine and remained more or less constant for twelve months. Since this time the pain had shifted lower down to the inguinal region, and was of a dull aching nature, with occasional sharp attacks lasting sometimes twelve hours, shooting to the glans penis and accompanied by great desire to micturate. These attacks have become much more frequent of late months and are more severe in character, causing patient to cease work, sometimes for a week at a time. Twice during the last twelve months he has had a sharp attack of hæmaturia, lasting five to six days.

Per rectum the lower end of the left ureter is felt to be thickened, but no stone can be felt in it. Neither kidney can be felt, but there is tenderness on left side on deep palpation.

Cystoscopy.—The left ureteric orifice is surrounded by cystic-looking masses like small grapes and an area of œdematous mucous membrane passed downwards and inwards from it towards the trigone. The whole area around the orifice is congested, and urine flows from the orifice in a dribble without any force.

Right ureteric orifice is normal.

Remainder of bladder-wall is normal.

The inference from this cystoscopic examination is that there is an inflammatory process in the lower end of the left ureter, probably due to a descending renal stone, and it is proposed to explore the ureter by extra peritoneal operation for the removal of the obstruction.

The above six cases are a few of many I have selected to show the importance of a cystoscopic examination in cases of urinary disease. Many other cases could be cited but would occupy so much space in the GAZETTE that the above must suffice, though I might add that I have been enabled to show the presence of a small vesical calculus in several instances where repeated sounding has failed to detect the stone; we have seen many cases of intravesical prostatic enlargement, with its concomitant symptoms of difficulty and frequency of micturition, without being able to find any enlargement of the gland on rectal examination and before removing the prostate by Freyer's operation, whilst I could mention several cases of vesical tuberculosis which have been diagnosed by means of the cystoscope and which have previously been treated elsewhere without the true diagnosis being arrived at. Finally, I would repeat that in doubtful cases of urinary disease, no examination is complete without electric cystoscopy, but

the examination must be performed by one experienced in the use of the instrument, for it is only by constant practice that the surgeon can appreciate the changes in the bladder, mucous membrane, or ureteric orifices, to enable him to give an opinion upon what he sees.

I wish to express my thanks to Mr. Freyer and Mr. Pardoe for permission to make use of the above cases.

Testimonial to Dr. Eyre.

	£	s.	d.
Amount already announced, June 18th...	30	7	0
Mr. Arbuthnot Lane	3	3	0
Dr. Hale White	3	3	0
Mr. Golding-Bird	3	3	0
Mr. J. H. Parfitt	2	2	0
Dr. W. Bligh	2	2	0
A Sympathiser	2	2	0
Dr. C. Price Jones	2	2	0
Mr. Jacobson	2	2	0
Mr. Shenton	2	2	0
Mr. Symonds	2	2	0
Sir Cooper Perry	1	1	0
Mr. W. A. Maggs	1	1	0
Dr. Graham	1	1	0
Dr. H. Cooper	1	1	0
Dr. Wade	1	1	0
Dr. T. G. Stevens	1	1	0
Mr. J. H. Badcock	1	1	0
Mr. J. C. S. Peatson	1	1	0
Mr. J. L. Payne	1	1	0
Mr. C. S. Morris	1	1	0
Dr. R. G. Delbruck	1	1	0
Mr. A. W. Ormond	1	1	0
Mr. C. Wilkins	1	1	0
Dr. A. M. Daldy	1	1	0
Dr. H. W. Beach	1	1	0
Dr. F. G. Hopkins	1	1	0
Mr. J. H. Busteed	1	1	0
Mr. E. G. Henderson	1	1	0
Dr. E. W. Goodall	1	1	0
Dr. G. Danford Thomas	1	1	0
Mr. Kenneth Scott	1	1	0
Dr. H. Barber	0	10	6
Dr. A. J. Cleveland	0	10	6
Mr. H. Allport	0	10	6
Dr. J. Pickett	0	10	6

Kipling Prize Competition.

WITH regard to the prize competition which appeared in our last issue, the Competition Editor has sent in the following report:—Thirty-two lists in all were received. Of these twenty-eight were disqualified on account of the omission on the part of the competitors to enclose the six penny stamps required of them. Of the remaining four, two were from ladies, one was from a member of the Staff, who is disqualified for using an ordinary envelope, and one was from a house-physician enclosing (we suppose on account of importance) six penny stamps more than were necessary.

The winning list was from a lady, and contained sixteen correct solutions, and to her we tender our heartiest congratulations; but by her own request her name cannot be published and she wishes only to be known to the readers of the GAZETTE as "Simplicity." We regret to say that had the conditions been adhered to "Simplicity" would have been beaten by one point, for one of the disqualified lists comprised seventeen correct solutions. We were surprised to find that only the winning list contained a correct solution of number one. In only two cases was number ten solved correctly, and we were astonished to see the august personage, who wears gold-rimmed spectacles and until recently was retained by the authorities apparently for the purpose of amusing the children in a surgical ward, so basely neglected. All other numbers were guessed several times over. To those who feel insulted we would say: If the hat fits wear it; and to those who feel complimented, we can only assure them of our innocence of any intention so to do. A correct list can be obtained from the office of the Inspector of Nuisances. "Simplicity" has resigned the prize on account of the responsibilities it entails.

Notices.

ARMY MEDICAL SERVICE.

An examination for not less than 30 Commissions in the Royal Army Medical Corps will be held on 28th July next and following days.

Applications to compete should be made to the Secretary of the Army Council, 68, Victoria Street, London, S.W., not later than the 18th July, on which date the list will be closed. The presence of candidates will be required in London from 26th idem.

Candidates who are over the regulation limit of age at the date of the examination, will be permitted to deduct from their actual age any period of service in the field after 1st October, 1899, that they could reckon towards retired pay and gratuity, if such deduction will bring them within the age limit.

UNIVERSITY OF LONDON.

ROGERS PRIZE, 1905.

Under the will of the late Dr. Nathaniel Rogers, the Senate offer a prize of £100, open for competition to all members of the Medical Profession in the United Kingdom, for an essay on, "Anæsthetics, their Physiological and Clinical Aspect."

Candidates are informed that the Examiners will attach importance to the results of original observation.

Essays, by preference typewritten or printed, must be sent in to the undersigned so as to reach him not later than June 1st, 1905.

PERCY M. WALLACE, M.A.,
Secretary to the Senate.

March 23rd, 1904.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. C. E. Iredell, B. Moiser, B. H. Stewart, A. F. Hertz, W. M. Mollison, O. V. Payne.

Obstetric Dressers.—Messrs. R. Felton, D. Isaacs, W. N. May, F. Alcock, A. Leeming, E. W. Sheaf, H. M. Clarke, S. M. Wells (July-August).

Dressers in the Throat Department—Messrs. F. Alcock, H. M. Clarke, E. W. Sheaf, H. D. Wyatt, M. Maher, C. B. Penny.

Clerk in the Throat Department.—Mr. F. B. Lowe.

Assistant Surgeons' Dressers.—Messrs. E. L. R. Norton, A. W. Eyles, P. D. F. Magowan, J. G. Phillips, A. Shepperd (Mr. Lane); G. Cockcroft, W. H. Trethowan, A. Walker, F. A. Barker, T. H. Barton, C. W. Greene (Mr. Dunn); J. S. Bookless, A. S. B. Bankart, R. Davies-Colley, G. W. Goodhart, C. W. Ponder, W. H. Robinson (Sir Alfred Fripp); I. Valerio, H. J. Clarke, R. Willan, J. A. von Wiehe, H. Moyle (Mr. Steward).

Medical Ward Clerks.—Messrs. G. N. Bartlett, E. M. Harrison, E. C. Lowe, E. Alban, A. W. Berry, H. F. Vandermin, C. C. A. De Villiers, T. F. Wilson, S. Reader, G. Wacher, P. S. Mills, C. M. Ockwell, H. W. B. Walling, E. H. Paterson, J. E. Hodson, T. B. Layton, W. H. Miller, H. A. Pallant, G. R. Phillips, H. E. H. Tracy, A. Zorab, J. S. Farnfield, C. F. L. Leipoldt, E. P. Minett, J. L. Rankine, A. Alcock.

Surgical Ward Clerks.—Messrs. G. F. E. Allison, A. T. Rivers, E. Wragg, A. Davidson, S. W. Daw, M. M. Earle.

Clerks in the Skin Department.—Messrs. E. M. Harrison, E. C. Lowe.

Aural Surgeon's Dressers.—Messrs. F. Rogerson, J. M. Barrionuevo.

Post-mortem Clerks.—Messrs. E. Evans, F. Rogerson, R. W. Allen, B. W. Lacey.

Assistant Surgeon's Clerk.—Mr. C. F. L. Leipoldt (Sir Alfred Fripp).

Civil.

BEVERS, EDMUND C., M.A., M.B., B.Ch. Oxon., M.R.C.S., L.R.C.P., has been appointed Honorary Assistant Surgeon to the Radcliffe Infirmary, Oxford.

EVANS, JOHN, M.B. Lond., L.R.C.P., M.R.C.S., has been appointed Senior Assistant Medical Officer to the Shoreditch Infirmary, N.

MASON, S. HERBERT, M.R.C.S., L.R.C.P. Lond., has been appointed Honorary Anæsthetist to the Manchester Northern Hospital.

PEMBREY, MARCUS SEYMOUR, M.A., M.D., has been appointed to examine in Physiology at the University of Oxford in the First M.B. Examination *pro hac vice.*

THORNE, J. M., L.R.C.P. Lond., M.R.C.S., has been appointed Clinical Assistant to the Chelsea Hospital for Women.

SIMON, Dr. R. M., has been appointed Examiner in the University of Birmingham for the Russell Memorial Prize for this year.

WHITE, W. HALE, M.D., F.R.C.P., has been appointed an Examiner in Medicine at the University of Cambridge for the ensuing academical year.

WILKES, J. HAMILTON, L.D.S.R.C.S., has been appointed Honorary Dental Surgeon to St. John's Hospital for Diseases of the Skin, Leicester Square.

Naval and Military.

Staff-Surgeon ROBLEY H. J. BROWNE, R.N., has been appointed to the *Albion*, and Staff-Surgeon PERCIVAL M. MAY, R.N., to the *Triumph.*

Surgeon E. A. EVANS, R.N., has been appointed to the *Amphitrite.*

Surgeon-Lieutenant A. C. ELLIMAN, 1st Cadet Battalion the Queen's (Royal West Surrey Regiment), Rifle Volunteers, is promoted to be Surgeon-Captain.

Royal College of Surgeons of England.

Appointed members of the Board of Examiners in Anatomy and Physiology for the Fellowship for the ensuing year:—

L. A. Dunn, M.S., F.R.C.S., E. H. Starling, M.D., F.R.S.

Appointed members of the Conjoint Examining Board:—

First Examination, Elementary Biology.—T. G. Stevens, M.D., F.R.C.S.

Second Examination, Physiology.—J. B. Leathes, M.B., F.R.C.S.

Midwifery.—J. H. Targett, M.S., F.R.C.S.

Papers by Guy's Men.

A Case of "Latent" Pneumothorax. By Richard Bevan, L.R.C.P. Lond., M.R.C.S.—*The Lancet*, June 11th.

Strangulated Hernia in an Infant twenty-eight days old; Operation two days later; Recovery. By R. Clement Lucas, B.S., F.R.C.S.—*The British Journal of Children's Diseases* for June, 1904.

The Lumleian Lectures on Some Disorders of the Spleen. By Frederick Taylor, M.D., F.R.C.P. Lond., Lecture III.—*The Lancet*, June 11th.

Forms of Joint Disease met with in Medical Practice. By Wm. Hale White, M.D. Lond., F.R.C.P.—*The Bristol Medico-Chirurgical Journal* for June, 1904.

A Case of Cæsarian Section for Obstruction of Labour by a Pelvic Tumour. By W. C. Swayne, M.D., B.S. Lond.—*Ibid.*

A Case of Congenital Hypertrophic Stenosis of the Pylorus. By Theodore Fisher, M.D. Lond., M.R.C.P., and Newman Neild, M.B., Ch.B. Vict.—*Ibid.*

Sport.

CRICKET FIXTURES.

Saturday, July 2nd.
G.H.C.C., I., v. Gravesend, away, 11 a.m.
" II., v. R.I.E.C. "A," home, 2 p.m.
" III., v. Boro' Road College "A," away, 2 p.m.
Wednesday, July 6th.
" I., v. M.C.C., home, 11 a.m.
" II., v. Blackheath "A," away, 2.30 p.m.
" III., v. Mercer's School, away, 2 p.m.
Saturday, July 9th.
" II., v. Old Olavians, home, 2 p.m.
Wednesday, July 13th.
" II., v. Manor House School, home, 2 p.m.
" III., v. Quernmore School, away, 2 p.m.
Thursday and Friday, July 14th and 15th.
" I., v. Captain Laycock's IX., away, 11 a.m.

LAWN TENNIS FIXTURES.

Saturday, July 2nd.
G.H.L.T.C., I., v. Brixton Wanderers, home.
Saturday, July 9th.
" I., v. Harold, home.
Wednesday, July 13th.
" I., v. Blackheath, away.
Saturday, July 16th.
" I., v. Kent, away.

POLO FIXTURES.

Friday, July 8th.
G.H.S.C., v. Hatcham Cygnets, home.
Friday, July 15th.
" v. Old Alleynians, home.

Annual Sports.

The Annual Sports Meeting was held at Honor Oak Park on Wednesday, June 22nd, in magnificent weather. The meeting was a great success, a larger number of visitors than usual being present. The Staff were to the fore as judges and referees. It is regretable that more senior men do not compete, or at any rate support this meeting. It is rumoured that one resident was present.

100 YARDS.—This was run in three heats. Heat 1.—1, H. N. Eccles, 4 yards; 2, A. Zorab, 7 yards. Time 10⅗ secs. Heat 2.—1, R. Rankine, 3 yards; 2. S. Reader, 2 yards. Time 10⅘ secs. Heat 3.—1, B. J. Connolly, 4 yards; 2, C. M. Plumptre, 4 yards. Time 10⅘ secs. Final.—1, H. N. Eccles; 2, R. Rankine. 10⅘ secs.

HALF-MILE.—There were only three starters in this event. It was won easily. 1, H. N. Eccles, scratch; 2, W. H. Watson, 5 yards.

PUTTING THE SHOT.—This was well contested, four men putting over 30 feet. 1, P. Patey, 4ft., 36ft. 2in.; 2, H. Archer, 1ft., 34ft. 2in. 3, R. Rankine, 2ft., 33ft. 7in.

HONOR OAK PARK CORONATION SCURRY STAKES.—This was run in three heats. There was a good number of riders and the usual number of falls. Heat 1.—1, E. H. Crawley; 2, L. T. Baker; 3, —. Rattray. Heat 2.—1, H. J. Hills; 2, R. Willan; 3, A. Zorab. Heat 3.—1, —. Sims; 2, R. Davies-Colley; 3, W. G. Pinching.

120 YARDS HURDLES.—Heat 1.—1, E. M. Harrison, scratch; 2, C. H. Mills, 10 yards. Heat 2.—1, R. G. Oram, 10 yards; 2, S. Reader, 5 yards. Final.—1, E. M. Harrison; 2, H. Mills. Time 18 secs.

THROWING THE HAMMER.—1, R. Rankine, 5ft, 78ft. 5in.; 2, E. M. Harrison, scratch, 72ft. 10in.

ONE MILE.—Only three men started. Pilbeam went to the front in the last lap, but was beaten in the straight. 1, W. H. Watson, 40 yards; 2, E. L. Pilbeam, scratch; 3, T. E. A. Carr, 30 yards. Time 4 min., 47⅗ secs.

220 YARDS.—This race was well contested, there being 10 starting. 1, H. A. Eccles, 2 yards; 2, B. G. Connolly, 6 yards; 3, R. Rankine, 6 yards. Time 24⅘ secs.

VETERANS' RACE.—1, G. F. Hardy; 2, A. E. Holman.

440 YARDS.—1, A. W. Berry, scratch; 2, C. M. Plumtre, 8 yards: 3, H. N. Eccles, 5 yards. Time 55 secs.

LONG JUMP.—R. Willan, 3 in., 20ft. 4½in.; S. Reader, 1ft., 20ft. 3½in.

HIGH JUMP.—S. Reader, 2in., 5ft. 5½in.; J. E. Hodson, 2in., 5ft. 3½in.; C. H. Mills, 3in., 5ft. 2in.

THREE MILES.—Watson, with a good start, won easily. 1, W. H. Watson, 2 min.; 2, V. Townrow, 1 min.; 3, E. L. Pilbeam, scratch. Time of scratch man, 16 min. 3 secs.

RELAY RACE.—This was won by the Association Football Club's team, the Rugby team being second. 1, Association F.C.; 2, Rugby F.C.; 3, Cross Country, 4, Cricket; 5, Swimming. Time 3 min. 55 secs.

FINAL OF DONKEY RACE.—1, L. T. Baker; 2. A. Zorab; 3, Henderson.

Cricket.

GUY'S v. LONDON COUNTY.

This match was played at the Crystal Palace on Saturday, June 18th. Scores:—

GUY'S.

A. M. Tolhurst, b Haywood	2
H. D. Wyatt, c Banbury, b Haywood	2
F. A. Husbands, b Gregory	33
R. Willan, b Haywood	16
J. S. Bookless, b Gregory	15
H. Archer, lbw, b Gregory	0
H. Simms, c Golder, b Haywood	31
E. Whelon, b Gregory	8
S. M. Wells, c Gregory, b Haywood	23
S. C. Bowle, not out	10
L. G. Davies, absent	0
Extras	3
Total	142

London County.

W. L. Murdock, c Tolhurst, b Wyatt	22
J. M. Campbell, st Wells, b Wyatt	75
W. L. F. Frith, c Sub, b Wyatt	4
P. R. Waterer, b Bowle	14
Graham-Tennent, c Wyatt, b Bowle	2
C. Haywood, c Bowle, b Wyatt	4
F. Benton, c Archer, b Bowle	1
—. Golder, c Wyatt, b Bowle	0
W. Banbury, b Bookless	28
R. W. Gregory, c Wyatt, b Willan	40
—. Snow, not out	2
Extras	9
Total	201

PAST v. PRESENT.

This match was played at Honor Oak Park on Saturday, June 25th, resulting in a draw. Langdale and Causton played well for the Past and Barber and Wyatt for the Present. Scores:—

Past.

W. T. Hancock, b Bartlett	4
A. E. Causton, b Piper	45
H. Langdale, c Wells, b Bookless	74
J. H. Joyce, c Bartlett, b Bookless	4
S. C. Bowle, c Willan, b Piper	6
W. K. Steele, c Wyatt, b Davies	5
E. W. Strange, run out	8
T. H. Edey, c Barber, b Wyatt	4
C. H. Fagge, not out	17
O. V. Payne, c Barber, b Wyatt	6
S. Mutch, lbw, b Bartlett	0
E. M. Harrison, b Bartlett	7
Extras	25
Total	205

Present.

H. Barber, not out	85
H. D. Wyatt, c Hancock, b Bowle	36
H. Archer, run out	4
A. M. Tolhurst, c Hancock, b Bowle	6
J. Bookless, c Langdale, b Bowle	2
F. Husbands, c Hancock, b Bowle	2
H. Simms, not out	0
L. G. Davies, b Hancock	2
S. M. Wells, b Hancock	9
Extras	15
Total (7 wickets)	162

G. N. Bartlett, S. A. Piper, R. Willan did not bat.

GUY'S v. ST. MARY'S.

Semi-Final Inter-Hospital Cup.

This match was played at Chiswick on June 28th. Mary's made a very poor show. Going in first they were all out in an hour and a half for 50. Davies and Piper bowled very well. We made the runs for the loss of 1 wicket. Scores:—

St. Mary's.

E. W. Squire, b Piper	0
W. S. Mitchell, c Tolhurst, b Piper	13
W. T. Finlayson, c Davies, b Piper	1
H. S. Ollerhead, b Piper	2
J. J. Lourens, b Davies	9
E. W. Archer, c Barber, b Davies	12
H. L. Barber, c Wyatt, b Davies	5
A. A. Stratton, c Davies, b Wyatt	0
F. C. H. Bennett, b Davies	2
R. W. Neagle, c & b Davies	0
F. W. Hobbs, not out	2
Extras	4
Total	50

Guy's.

H. Barber, c Finlayson, b Ollerhead	67
H. Archer, lbw, b Mitchell	6
R. Willan, c Archer, b Mitchell	46
J. S. Bookless, c Neagle, b Finlayson	15
H. D. Wyatt, c & b Finlayson	80
A. M. Tolhurst, c Hobbs, b Ollerhead	0
F. Husbands, b Squire	34
H. Simms, c Ollerhead, b Stratton	40
S. M. Wells, c Squire, b Stratton	12
L. G. Davies, b Stratton	0
S. A. Piper, not out	1
Extras	11
Total	312

GUY'S 2nd XI. v. BART.'S 2nd XI.

Junior Cup Tie.

This match was played on the University Ground. We won the toss and batted first, compiling 168. Moyle played a useful innings of 39, and Harvey and Whelon put on over 40 when together. Bart.'s were all out for 52, Russell taking 6 wickets for 33, Bartlett 4 for 13. Scores:—

Guy's.

A. Leeming, c Craddock, b Smith	19
R. S. Bennet, c Craddock, b Adams	7
E. L. Norton, c Symes, b Adams	0
E. Whelon, c Remington, b Craddock	25
T. R. Harvey, b Horner	28
B. T. Verver, b Horner	15
G. N. Bartlett, b Horner	3
H. H. Moyle, b Craddock	39
S. Mutch, c Portsthwaite, b Adams	3
G. Russell, c Walker, b Craddock	5
G. E. Rice, not out	0
Extras	24
Total	168

Bart.'s.

E. N. Snowden, b Russell	0
B. A. Keats, b Bartlett	0
J. N. Smith, c Norton, b Russell	33
H. Remington, b Russell	0
L. S. Philips, c Leeming, b Bartlett	1

J. M. Portsthwaite, b Russell	0
A. J. Symes, b Russell	12
N. H. Walker, c Harvey, b Bartlett	0
C. E. Adams, c & b Bartlett	0
J. Craddock, b Russell	1
N. G. Horner, not out	0
Extras	5
Total	52

GUY'S 2ND XI. v. CROFTON PARK.

This match was played at Honor Oak Park on June 15th. Our opponents batted first and made 183. The match was won against time for the loss of 6 wickets, thanks to an excellent innings by Wyatt and steady help by Harvey.

CROFTON PARK.

S. A. Hunter, b Bartlett	36
C. S. Phillips, b Rice	34
Theobalds, c Leeming, b Bartlett	36
J. Simpson, b Leeming	5
P. J. Hunter, b Leeming	4
H. L. Gallop, c Wyatt, b Leeming	15
J. D. Taylor, c Leeming, b Bartlett	0
G. Bradshaw, b Bartlett	7
C. W. J. Leper, not out	18
P. W. Hill, c Leeming, b Wyatt	10
F. Sharp, b Wyatt	0
Extras	18
Total	183

GUY'S 2ND.

H. Archer, b Gallop	6
T. L. Johnston, b Gallop	36
S. C. Bowle, b Gallop	8
A. Leeming, c Hunter, b Gallop	0
H. D. Wyatt, not out	101
D. Reynolds, b Taylor	0
T. R. Harvey, b Theobalds	20
Extras	14
Total (6 wickets)	185

S. Mutch, H. H. Moyle, G. N. Bartlett and G. E. Rice did not bat.

GUY'S 2ND XI. v. ADDISCOMBE "A."

This match was played at Honor Oak Park on Saturday, June 18th. We batted first and compiled 212 for 9 wickets, of which Barber made 106, without giving a chance until he had got his century. Addiscombe made 164 for 6 wickets, Curry making 83 not out.

GUY'S 2ND.

H. Barber, c Cooper, b Newcombe	106
R. S. Bennet, b Newcombe	1
E. L. Norton, c Herbert, b Newcombe	14
J. L. Johnston, c Hodges, b Newcombe	4
T. R. Harvey, b Barker	17
H. G. Gibson, c Herbert, b Newcombe	0
H. H. Moyle, b Darvill	26
G. E. Rice, b Darvill	13
B. T. Verver, c & b Newcombe	3
G. N. Bartlett, not out	15
G. Russell, not out	10
Extras	3
Total (9 wickets)	212

ADDISCOMBE.

J. W. Cooper, b Verver	1
R. B. Herbert, c Norton, b Russell	0
T. E. Curry, not out	83
W. Hodges, b Bartlett	19
F. Newcombe, c Johnston, b Bartlett	4
V. Darville, b Moyle	3
G. P. Hodges, c Johnston, b Bartlett	40
Extras	14
Total	164

G. H. Martin, S. Mutch, R. E. Baker and P. N. Davis did not bat.

GUY'S 2ND XI. v. OLD COLFEIANS.

This match was played at Lee on Saturday, June 25th, resulting in an exciting win for Guy's by 4 runs. Leeming played a good innings for 43. Iliffe and Jones made a great stand for the ninth wicket, and succeeded in putting on 36 for that wicket, making a win for the hospital. Scores:—

GUY'S.

A. Leeming, c Denny	43
H. H. Moyle, c Denny	7
R. S. Bennett, b Ross	0
A. V. Taylor, c (?), b Denny	9
T. R. Harvey, b Ross	5
E. L. Elliott, c Bills, b D. Denny	6
B. T. Verver, c Norfolk, b D. Denny	1
O. G. Iliffe, c Mayne, b Ross	19
G. E. Rice, not out	1
A. G. Jones, c Bills, b Ross	17
M. Munden, lbw, b Denny	0
Extras	4
Total	112

OLD COLFEIANS.

H. C. Bills, c Harvey, b Rice	12
A. C. Denny, c Verver, b Rice	0
K. Trouside, c Taylor, b Rice	46
D. Denny, c Jones, b Verver	4
T. Coppinger, b Verver	1
—. Mayne, b Moyle	7
W. Coppinger, c Jones, b Moyle	2
—. Taylor, b Leeming	16
—. Ross, c Munden, b Moyle	0
—. Smither, b Leeming	9
P. Denny, not out	6
Extras	5
Total	108

Reviews.

The price of books submitted for review should in every case be stated.

Medical Laboratory Methods. By H. French, M.D., M.R.C.P. (Ballière, Tindall & Cox.) pp. 152, price 3s. 6d. net.

A short handbook designed for use in the medical laboratory.

On chemical examinations each test is fully described, and the clinical significance of the presence of the abnormal ingredient noted, and this is followed by a detailed list of the fallacies of each test with a mode of differentiation.

On the blood, detailed methods of preparation and means of identification are given.

The book will be valuable to men at work in the clinical laboratory.

Manual of Surgery.—Vol. 2: Regional Surgery. By Alexis Thomson, F.R.C.S. Edin., and Alexander Miles, F.R.C.S. Edin. (Young J. Pentland.) 724 pp.

This, the second volume of the same handy size, deals with diseases of special parts and their treatment. It fulfils the requirements of a handbook in being sufficiently full and yet not too long.

Like the preceding volume, this is profusely and well illustrated.

Materia Medica, Pharmacology and Therapeutics. Inorganic Substances. By Charles D. F. Phillips, M.D. (Longmans, Green & Co.) Pp. 921. Price 21s nett.

This, the third edition, revised and brought up to date, will be found, from the point of view of therapeutics at least, to be all that can be desired.

The consideration of baths (vapour, air and light) and of medicinal waters is full of useful information. Nearly all the spas are recorded, with the special accredited medicinal value of each and the affections generally recognised as being relieved or cured by taking their waters.

In the same strain the acids and metals are exhaustively treated.

Throughout the book the great feature is the space and matter devoted to therapeutics, rendering the book a valuable one to the medical man as a source of information and as a reference.

The Case against Anti-Vivisection. By Stephen Paget. (The Scientific Press, Ltd.). pp. 104. Price, 2s. net.

Divided into four parts. The first; a short sketch of the origin and rise of anti-vivisection (in the medical journals); the societies and their want of unanimity. The second, with their literature and its tone, for example, "The *Medical Brief* calls anti-toxin the fraud of the age. It would be nothing less than ghoulishness to inject the matter from an abscess into a child's arm, yet antitoxin is not much better; it is the decomposing fluid from a diseased horse partially neutralised by carbolic acid."

The third, dealing with their arguments and exposing their inaccuracy from gross neglect of detail, or misrepresentation arising from inability or lack of desire to understand facts and figures.

The fourth part by extracts from their authorised publications shows their style of propagandism and the means of coercion resorted to.

The tone, maintained throughout, is reserved and dispassionate. We gather that the harm the movement is capable of doing is not small, and the good limited, for the lay mind becomes confused and biassed amid medical terms and technical niceties which even the leaders themselves fail to understand or comprehend; hence their inaccuracy and illusions.

Calendar.

July, 1904.

Sat. 2.—Messrs. Golding-Bird and Dunn's take-in; Drs., J. E. Scales and M. Leckie; Cl., C. E. Iredale.

Mon. 4.—Intermediate M.B. Lond. Exam. begins.
First part of Conjoint D.P.H. Exam. begins.

Tues. 5.—Final Conjoint Exam. begins.
Guy's Biennial Festival.

Wed. 6.—**Distribution of Prizes by the Right Hon. the Viscount Goschen.**

Thur. 7.—Messrs. Jacobson and Sir Alfred Fripp's take-in; Drs., E. H. Adams and H. A. Watney; Cl., A. F. Hertz.

Fri. 8.—August Appointment List closed.

Mon. 11.—Second part of the Conjoint D.P.H. Exam. begins.
Pre. Sci. M.D. Lond. Exam. begins.

Wed. 13.—School Exam. in Histology begins.

Thur. 14.—Messrs. Symonds and Steward's take-in; Drs., G. Hamilton and H. S. Knight; Cl., B. Moiser.

Sat. 16.—School Exam. in Histology.

Solution of Case for Diagnosis.

Chronic intussusception with strangulation.

Births.

CROKER-FOX.—On June 25th, at Knole Lodge, Bournemouth, the wife of H. E. Croker-Fox, M.B., of a daughter.

HAYES-PALMER.—On June 20th, at 6, Cumberland Mansions, West Hampstead, N.W., the wife of P. H. Hayes-Palmer, L.D.S.R.C.S. Eng., of 112, Harley Street, W., of a son.

Marriages.

DOWSETT—WEBB.—On June 8th, at the Parish Church, Walton-on-Thames, Ernest Blair Dowsett, L.R.C.P. Lond., M.R.C.S., L.D.S. Eng., to Ethel Ellen Sarah, elder daughter of Percy H. Webb, Esq., of Walton-on-Thames.

RECORDON—LAW.—On June 27th, at Queen's Hotel, Dundee, by the Rev. C. M. Grant, Ralph Bertram, L.D.S. Eng., son of David E. Recordon, Esq., of Streatham, London, to Jane Lawson, daughter of James C. Law, of 1, Oakewood Terrace, Dundee.

SAWARD—WHITTEN.—On 20th June, at St. George's, Hanover Square, W., by the Rev. F. P. Woodward, M.A., Arthur H. M. Saward, M.R.C.S. Eng., L.R.C.P. Lond., of Richmond, Surrey, to Violet, eldest daughter of the late A. J. Whitten, I.C.S., of Upper Norwood.

Death.

SHAW.—On 21st June, at Guy's Hospital, Robert Charles Baskerville Shaw, of Guy's Hospital, aged 22.

R. E.—ED.

GUY'S HOSPITAL GAZETTE.

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CONTENTS.

	PAGE.
Passim	285–288
Pass List	288
Two Cases of Cæsarean Section. Clinical Lecture by P. Horrocks, M.D.	288–293
The Biennial Dinner	294–295
Papers by Guy's Men	295
Prize Day	295–305
Obituary—Mr. John Birkett...	302
Testimonial to Dr. Orloff Combe	302
In Lighter Vein	303–304
Correspondence	304
Appointments	304
Reviews	305–306
Sport	306–308

Passim.

BY the death of Mr. Birkett, the Hospital loses the oldest member of its Consulting Staff—one so old that he is remembered by but few of the present Staff. It is interesting to note that the year of his resignation was that during which Mr. Lucas was elected an Assistant Surgeon, while two years earlier Dr. Taylor had been appointed Assistant Physician. To carry history a step further back still, we may say that Sir Thomas Stevenson dressed to him. He was the author of "Diseases of the Breast," and several articles in Holmes' "System of Surgery," having gained the Jacksonian Prize for 1848. Of recent years he has very rarely been seen about the Hospital, and through the hardness of fate he died on the Hospital Prize Day, a function which has grown to very large dimensions since he knew it. Prognosis was his forte, and he was often known to correctly predict a patient's death to the very hour; such a gift is given to few men. In these days of blood counts the art of prognosis is not sufficiently taught, the general aspect of the patient is obscured by the observation of minute and often unnecessary details.

SUN, fine weather, gorgeous robes and gaily-dressed ladies all combined to make Prize-day this year a great success. Those of us who were fortunate enough to get into the lecture-room were rewarded by some brilliant speeches, especially that of Viscount Goschen, who, perhaps, might have honoured us by appearing in his robes as Chancellor of the University of Oxford. Perhaps the protest uttered in the GAZETTE last year reached the many ears it was intended to reach, for the whole proceedings, and especially the speeches, were commendably short. This is a great improvement, as lecture-rooms are far too frequently associated with somnolence. The gowns and hoods were as gorgeous as ever—perhaps in some instances the brilliance of the gown was in inverse ratio to the quality of the degree. The list given in our last issue by no means covered all those which were seen. We noticed particularly one gentleman with three hoods on, and another in a claret-coloured gown with a white lining.

SHOULD we be guilty of *lèse-majesté* if we hazarded an opinion that the band did not quite come up to the reputation of the First Life Guards, or was it that their selection of music was ill-made? Refreshments were, as usual, served in a big tent in the Surgery Court, and it must have been comforting to the contractors to know that policemen were on duty in Cornelius, in view of the enormous "silver"

urns which they had provided. The visitors seemed to us fewer in numbers than usual, though they filled the wards, where they admired the pet baby and the unique floral decorations. On Prize Day the Hospital unbends, and even the sedate house-surgeon can be seen taking ladies round his ward, cousins—his own—or sisters—other men's.

We publish in another column a letter from the Chaplain, which describes an excellent scheme about to be set on foot, and for which he solicits subscriptions. The memory of nurses and students who die at their posts ought to be perpetuated, and the chapel is a fit and proper place for such a memorial to be erected. The scheme proposed sounds very feasible, and has the merit of allowing the work to be done in detail as the money comes in—an important point in such memorials. To the list of names to be commemorated we should like to see added those of Guy's men who die while acting as residents of other hospitals, instances of which will readily occur to many. Though not actually serving Guy's at the time, they are assisting in administering medical aid to the poor, especially as must happen during epidemics at fever hospitals. Those wishing to subscribe would be glad if the committee would give some estimate of the cost, so that subscriptions might be given accordingly.

The Biennial Dinner, which was held on July 5th, proved a great success, thanks in no small degree to the untiring efforts of Dr. Newton Pitt. The dinner is held at 6 p.m., such an early hour being chosen, we believe, so that those old Guy's men who live some distance from Town may be able to get home the same night—but we doubt if an hour makes much difference to them, while on the other hand it must be very hard to get London medical men to dine so early. We were pleased accordingly to hear Dr. Pitt suggest 7 o'clock as a more suitable time for future dinners, and also noted his very excellent suggestion that for the future intending diners should give him as long a notice as possible, so that greater efforts might be made to enable as many men as possible of the same decade to sit together. We imagine it would be an impossibility to bring together any particular residents, say of five years ago, but how interesting to hear the conversation! Dare we say that diagnoses would be more guarded, and treatment less radical? We imagine also, that fines would be unnecessary.

Posthumous fame is a flower of a day at Guy's, where generation fast treads down generation, but there must be many whom the Colonnade still knows that remember Arthur Pearson, the genial President of the Residents of two Christmases ago. Such ones—and many others—will be interested to have news of his doings since he left this humdrum land for the more spacious regions of Central Africa and its prospects of big game shooting. He has sent home the diary of his travels, and it is now being published in the *Empire Review* in serial form. The two instalments that have already appeared give ample promise of future adventure, for what else can you expect of a respectable ex-H.P. who deliberately and of malice prepense insists on trying his 'prentice-hand in a native dug-out, solus-cum-solo, on a steamy African river alive with gigantic crocodiles and ponderous hippo.? Those of us who gasp for air, for Boro' air, these dog-days, will read the diary and wonder why we stay at home when there are still countries teeming with buck and antelope, buffalo and lion, and still social intercourse where a starched collar is the height of affectation, and zebra-steak the plat-du-jour.

We have much pleasure in announcing that Mr. H. W. Brown, whom all will remember as one of Mr. Golding-Bird's house-surgeons, has been appointed Resident Medical Officer at Kasi-el-Ainy Hospital, Cairo. High authority enables us to state that this appointment was gained by Mr. Brown principally through his knowledge of tropical medicine. It is well known that a man who possesses a D.P.H. is able to get many appointments not open to his less fortunate brethren, and it is now evident that tropical medicine will perhaps prove an avenue to success for many others; at any rate

it is a most important subject, the study of which well repay both scientifically and pecuniarily.

In the *Daily Mail* for July 4th, appeared a description of an evening emergency operation at a London hospital. In the minds of those who were present but little doubt can exist that Guy's is the hospital mentioned. Our only regret is that the writer—better known as a modern day poet of no mean merit—fainted at the critical point; otherwise we might have been treated to a description such as would have outshone Tolstoi or Zola. The article is well written and not too highly coloured, though to us who see so many operations, a few of the phrases may seem to require the blue pencil. We particularly like the description of "the two sisters, with set faces and averted eyes, waiting." Wild horses will not drag their names from us. Again, we understand that "the young house-surgeon" has since left the hospital in disgust at being so described. A vivid piece of writing, not overdrawn, and such as should make the stoney-hearted open their hearts, and loose the strings from the necks of their money bags.

Mr. Lulham, whose recent work we review in another column, is an old Guy's man who will be remembered by many old Guy's men, as he identified himself so closely with the Disguysed Minstrels. He entered as a student in 1883, and was with us for some time, though bad health took him abroad at intervals for long spells. Passionately fond of music, his assistance was in great demand at concerts, where his musical sketches always won much applause. A clever article by him appeared in the Gazette, "My Christmas Party,"—he wanders into the dissecting-room on a Christmas Eve and inadvertently interrupts a convivial evening which "the subjects" are holding.

In the biography of Dr. Moxon, which appears in an old volume of the Reports, we found a reference to his "magnificent and unique series of pathological drawings which are kept in the post-mortem theatre of Guy's Hospital." We naturally expected to find this collection preserved as one of the greatest treasures of the Hospital. It was therefore almost with a feeling of horror that we found the pictures piled carelessly together under a table in the post-mortem room. A sheet covered them, apparently to hide the disgraceful condition to which damp and dirt have been allowed to bring them. Many of the drawings are completely obliterated; none have entirely escaped. It is useless now to enquire who is responsible for the neglect which has ruined these beautifully-executed watercolours, which should have been religiously cared for as a lasting memorial of one of our greatest pathologists. All that we would add is that the authorities should take immediate steps to have them examined by an expert, in order that an attempt may be made to save as many as possible from complete destruction.

We heartily congratulate our first and second Cricket teams on reaching the final round in the Inter-Hospital Cup Ties. The final of the Senior Cup is fixed for Wednesday and Thursday next at Winchmore Hill, when we play London—and may success be ours. The second team overwhelmingly defeated London II., and have thus qualified to meet Thomas's II. in the final of the Junior Cup Ties. The winning of both these Cups would make up for losing the Football Cup earlier in the year.

Thanks to the great generosity and kindness of Mr. and Mrs. Cosmo Bonsor, the Sisters and Nurses, those holding house appointments, a few Members of the Staff and their wives, and several other fortunate ones, spent two most enjoyable afternoon's on the Treasurer's estate at Kingswood in Surrey. Soon after mid-day on the Wednesday and Thursday of this week a special train carried the party to Kingswood and brought them back to London Bridge at about seven o'clock in the evening. The weather was superb, and we should not imagine that the country around could ever look prettier than it does at present. Nothing was forgotten by the host and hostess that could in any way add to the pleasure of their guests. The time passed

all too quickly, as is always the way when enjoyment is keen. We feel sure that in thanking Mr. and Mrs. Bonsor we are voicing the sentiments of all who enjoyed their hospitality.

WE have been asked to announce that the Goblins Club will hold its Annual Dinner on Thursday, July 21st, at 7.15, at the Café Royal, W., and that application for tickets should be addressed to Mr. Percy Henry, 79, King William Street, E.C.

Pass List.

University of Oxford, Trinity Term, 1904.

EXAMINATION FOR THE DEGREE OF MASTER OF SURGERY (M.CH.).

P. N. Blake Odgers.

FINAL EXAMINATION FOR M.B. DEGREE.

MEDICINE, SURGERY, MIDWIFERY, FORENSIC MEDICINE AND PUBLIC HEALTH.—A. F. Hertz, A. R. Wilson.

University of Cambridge, June, 1904.

BACHELORS IN MEDICINE.

H. Ackroyd, A. R. Brailey, J. S. Cooper, H. A. Cutler, J. H. Donnell, C. R. Howard, C. M. Murray, R. D. Smedley.

BACHELORS IN SURGERY.

E. Bigg, A. R. Brailey, J. S. Cooper, H. A. Cutler, J. H. Donnell, J. Goss, C. R. Howard, W. M. Mollison, B. H. Stewart, A. Wylie.

SECOND EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES.

B. K. Nutman.

Second Conjoint Examination, July, 1904.

H. P. Aubrey, A. Alan Forty, A. L. Foster, F. Holcombe Fuller, P. V. G. Pedrick, J. T. Smalley, St. J. A. M. Tolhurst, J. N. Watson.

Two Cases of Caesarean Section.

CLINICAL LECTURE BY PETER HORROCKS, M.D.

Monday, May 9th, 1904.

GENTLEMEN,—Within the last six weeks we have had in the hospital two cases of Cæsarean section, and it seems to me a favourable opportunity for saying a few words about this operation, which, like many others is much more frequently performed nowadays, than formerly. Whether Julius Cæsar was delivered by abdominal section I am not prepared to prove, though most people believe that he was, and hence the name. Be that as it may, the operation of Cæsarean section means removing the child from the uterus by cutting into the uterus. And until lately that meant by cutting into it through the abdominal parietes. It is now sometimes recommended to do Cæsarean section by cutting the uterine wall through the vaginal roof. In the pre-antiseptic days Cæsarean section was nearly always fatal. I can show you the standard works of the time which stated that Cæsarean section was a perfectly unjustifiable operation, and that it always meant death to the mother. You can see why that was; because Cæsarean section was not undertaken except as a last resource. It was not undertaken simply to save the child's life, for the child was usually dead long before the question of the operation was discussed. Attempts were made to deliver the child through a narrow pelvis, and only when such attempts failed was Cæsarean section considered. I remember the late Braxton Hicks telling us, when I was a student, that he could deliver through a conjugate diameter of two inches, because the cephalotribe is only one and a-half inches across at its widest diameter, and by crushing the child's head repeatedly from one side to the other, and then twisting this crushed head round, so that the blades of the cephalotribe came into the conjugate of the mother he could draw it through a diameter of two inches, for he allowed half an inch for the spring of the blades and for the soft tissues. Naturally the mortality of such cases was 100 per cent. so far as the fœtus was concerned, and it was very high for the mother. But it was nothing like that of Cæsarean section, which was practically always fatal to the mother in those days. But it is not fair to compare our successes with their failures, for this reason, that our successes are not due so much to the fact that we can save these women

whom they could not, but that we operate in a different class of case altogether. We operate by election. You can allow a patient to go on to full time and promise a living child, almost certainly, and the risk the patient runs is comparatively little. On taking a bird's-eye view of the evolution of the method of doing Cæsarean section, you will see that there was an operation recommended by an Italian doctor that was superior to Cæsarean section at a certain stage of the attainment of asepsis. It was that known as Porro's operation, which is simply Cæsarean section *plus* removal of the uterus. You thereby saved more patients than if you left the uterus *in situ*. Why? Because antisepsis was not sufficiently studied, nor asepsis sufficiently attained. Thus the wound in the uterine wall was a source of danger to the mother, as it often suppurated and set up a fatal peritonitis. It was attributed to the soiling of the peritoneum by the child, by the vernix caseosa, or by the liquor amnii; to anything rather than to the fingers of the operator or to the technique of the operation being imperfect. But now, if you are quite aseptic in all you do, you find the liquor amnii and the vernix caseosa are aseptic, and the uterine wound does not inflame. So that Porro's operation is now no longer done; and you find from modern statistics that Cæsarean section is just as good in reference to the mortality of both child and mother as was Porro's operation, and in fact rather better, because obviously, Porro's caused much greater shock, and it is now only resorted to in a small proportion of cases, such as where there is a ruptured uterus. If you find an ugly rent in the uterine wall, running low down—and they generally do, because as a rule rupture of the uterus is due to some obstruction of labour—the uterus tries to expel the body but cannot, and the child's head stretches the lower segment. The rupture nearly always runs up and down, because by the law of fracture you get the tear at right angles to the line of tension. If you find such a rent you may say it will be safer for the woman to have her uterus removed, because part of the rent is too low down to stitch, or if it can be stitched it will take a long time. But I recommend you *not* to remove the uterus. You will find it safer to pack a little gauze into the rupture, and let one end go down into the vagina, which will drain it, and it will result in less shock to the mother. So you may find you will never do Porro's operation when you get into practice.

Both the cases which I bring before you today are interesting, as they illustrate Cæsarean section undertaken for two very ordinary causes. The first one was done for contracted pelvis. Those of you who are in for examinations will have to discuss Cæsarean section and contracted pelvis. The most important diameter, from the obstetric point of view, is the conjugate. Why? Men talk about the conjugate of the outlet. There is no such thing; there is only one conjugate, and that is the antero-posterior diameter at the brim, between the promontory of the sacrum and the top of the symphysis. Why is that the most important diameter? Because it is the narrowest diameter of the brim, and the one most frequently contracted. It is not the narrowest of the whole pelvis. In between the tuberosities of the ischia is the narrowest part, but the child never gets stuck there.

In the first case the poor woman had a contracted pelvis, and when she came to me five years ago I found she had a diagonal conjugate of four inches and an external conjugate of six and a half inches. Deducting half an inch from the diagonal you get three and a half inches as the true conjugate. According to some people that would be large enough to justify the induction of labour at the seventh month. Well, do it at the seventh month and perform version, and deliver the child feet first, and how many children do you think you will get alive? The child is only small at seven months, and it would not be able to breathe well; and if it were alive when born it probably would not live long. But think of the extension of the arms above the head and the child's cord getting down between the child and the pelvic brim, and you have a woman with a conjugate of three and a half inches. If you do not pull, it will not be delivered quickly enough, and if you do pull the arms and head get extended, and you put your fingers up and try to get the arms down, flex the head and get the child born; and should you succeed perhaps it will never breathe owing to the injuries it has sustained, so you have lost the child anyway. The mother may be all right as long as you deal with her aseptically. It is not fair to compare present day operations of Cæsarean section with induction of labour in pre-aseptic days. You may say that nowadays the mortality of mothers in induction of labour or miscarriage is practically *nil*; certainly it is under 1 per cent., and in the best hands the mortality in Cæsarean section is not less than 3 per cent. or 4 per cent. So it is not fair to say that a woman's chances are as good with Cæsarean section as with one of those other operations. Still, 3 or 4 per cent. is vastly different from 100 per cent. of former days. I

said to the patient, "If you like I will try and give you a living child by doing an operation," and I tried to explain what symphysiotomy was. Those who have never seen symphysiotomy done will be surprised to learn how widely the symphysis can be separated.

In the first case I saw the separation was so wide that one did not know what the condition of the sacro-iliac synchondrosis could be. But all those joints become, during pregnancy, more movable, and there is more fluid in them, and the ligaments are more plastic. Thus you are able to get an increase of half an inch or more in the conjugate. We delivered this woman of a living child by symphysiotomy, and it is alive now. We sewed up the symphysis with silver wire, and she has got it in now. We hammered it down with a mallet, and made her pelvis as good as we could. Five years later I found the mother was pregnant again, and she wanted miscarriage inducing. I said, "If I induce miscarriage for you there will be a certain amount of risk in doing it; but in all probability you will become pregnant again, and we shall have to do it a second, and perhaps a third time, whereas if you will go on till full term, I will give you another living child and at the same time sterilise you and thus prevent you having any more, the risk of the operation being no greater than the sum of the repeated risks of several induced miscarriages." I told her the operation would differ from the last, as I did not care about cutting the symphysis again and removing the silver wire. She allowed me to do Cæsarean section, and I think some of you were present when I did it. The child, a boy, was a very fine one, and she has now got two living children, both of whom she nursed, as she had plenty of milk on each occasion.

The other case was one which had cancer of the cervix. She was brought up in labour from Blackheath or Lee, by Dr. John and Dr. Leopold Burrows; and they found that the os would not dilate, and that it bled when touched. We found the cervix uteri infiltrated with cancer all round, and that it would not dilate; if an attempt were made to force it open it would break. To have dragged the child through that cancerous cervix, and to have split and damaged it in that way, would probably have been fatal to the mother. Therefore we did Cæsarean section. Both mother and child (a girl) did very well. In fact you would not have imagined had you seen her nursing the baby that she had had anything beyond an ordinary normal labour. Every medical man should know what Cæsarean section is and be able to perform it. Anybody can attend a woman in labour. Parturition is a physiological act, and if nobody is there to assist it will be carried out to perfection in the vast majority of cases. A medical man should be able to do more than a midwife or a student who has never been to a case before in his life. I am sure every one of you could perform Cæsarean section if you had the necessary courage, and that which will give you courage, namely, knowledge. I shall try to tell you how to do Cæsarean section so that you can perform it. This woman with cancerous cervix is coming in on Monday to have her uterus removed, because, although the cancer prevented expansion sufficient to allow of the passage of the child, it was not sufficiently far advanced to prevent the removal of the uterus. One or two of you saw this patient, and you were struck with the effect of involution upon the cancer. Before the Cæsarean section, it felt as if the cancer was very extensive, but since she has gone through the process of involution—for we have had her in Queen ward five weeks—it has subsided so much that obviously we shall be able to remove the whole uterus by vaginal hysterectomy.

It seems to be an early case. If a woman comes to you with a contracted pelvis, say three inches, two and a half, or two inches, you must be able to discuss the matter, both in examination papers and in practice. If you induce labour for any diameter less than three and a half inches I do not think there will be much chance of your having a living child. I think you will agree with me that if a woman had a condition whereby she could not have a living child naturally, it would be justifiable to obviate the danger by the induction of miscarriage. But it is not long since a man got up at a meeting and said it was unjustifiable in these days to do that. He said it is no more dangerous to do Cæsarean section than it is to induce a miscarriage. But I do not think so. I think there is a difference of one or two per cent. in the mortality of induction of miscarriage and Cæsarean section when both are done by election aseptically. These men say the woman is sure to become pregnant again and you will have to go on inducing miscarriage. Certainly, do it every time. If it is justifiable once it is justifiable again. The induction of miscarriage is not more but less dangerous than Cæsarean section. The mortality from the former in skilled hands is nearly *nil*, though of course it is very different in the case of criminal abortionists, who do the operation secretly and probably with septic instruments, whereas the

mortality in Cæsarean section in best hands is two to three per cent. Still it must be remembered that in the induction of a miscarriage a life is sacrificed which would be almost certainly saved by Cæsarean section, and also that the sum of the risks of repeatedly inducing miscarriages would equal the risk of one Cæsarean section when the woman could be sterilised so as to prevent future pregnancies.

In the varying degrees of pelvic contraction, in cancer of the cervix, in cases of narrowing of the parturient canal by tumours, cicatrices, &c., each case must be decided on its merits. It may be justifiable to get out of the difficulty by inducing miscarriage; the induction of premature labour may in some cases offer the possibility of obtaining a living child. Forceps and axis traction may occasionally succeed as may Podalic version; few cases would be suitably treated by symphysiotomy, but as I have already explained to you, this operation is being replaced by Cæsarean section, as is also the operation introduced by the late Professor Porro.

Supposing you had a case of Cæsarean section to do, would you prefer to wait till the woman is in labour, or to operate at any time you like? Those who recommend waiting till the patient is in labour argue that if the uterus has begun to contract with real labour pains you are less likely to get post-partum hæmorrhage, because the contractions will probably stop the hæmorrhage. But what does experience tell you? If you operate upon a woman who is not in labour does she bleed to death? Does not the uterus contract? It does contract perfectly well. In our case where symphysiotomy had been performed five years before, we waited till the 280th day after the last period. We had her in the hospital a fortnight before, and we were ready to do it at any moment. But she did not come on in labour, and I arranged to do it one afternoon at three o'clock when she was not in labour. We did the operation and the uterus contracted perfectly well. So my advice is, don't wait till the woman is in labour, but do it at a specific appointed time, then you choose daylight, and have your instruments and your assistants all in readiness. Those advantages outweigh the supposed disadvantages of the uterus being unprepared to contract. You cannot take the uterus by surprise at the 280th day; it will contract and stop the bleeding.

With regard to the length and position of the incision in the abdominal wall, some books, even nowadays, speak about pulling the whole uterus out of the abdomen in order that they may slip round it an elastic band, which is then drawn tightly round the lower end in order to control the uterine vessels and the pampiniform plexus. In order to do that they have to make a long incision. That elastic band put round to prevent hæmorrhage, I believe, does more harm than good, even in the way of hæmorrhage. I remember many years ago saying at a meeting of the Obstetrical Society that I thought this elastic band did more harm than good, and the late Matthews Duncan, who was a very great authority, and whose word, of course, one had the greatest respect for, said that whatever Dr. Horrocks might think, as a matter of experience, this elastic band did not cause the women to bleed to death afterwards. It may not, but I tell you it is unnecessary to put that elastic band round. And in order to do it, it is obligatory to pull the uterus out through the abdominal incision, which must therefore be a very long one. I recommend you to make an incision beginning at about two inches above the navel. I do not practise going right through the middle line, cutting the navel, and sewing it together afterwards; but to one side, and passing down three inches below. A five-inch incision is long enough, and when you are doing it never forget that the abdominal wall is so greatly attenuated by the stretching of the pregnant uterus that your knife is in the latter in a moment. I have more than once, when forgetting this, cut straight into the uterus. Even in fat women the fat gets spread out into a thin layer, and in a thin woman there is scarcely anything but skin, especially if she has had children before. You may enter the uterine wall before you know it. It does not very much matter, but you want to know exactly when you are doing it; therefore, cut carefully. When you have made the incision I have described, and pinched up any vessel in the abdominal wall which may be bleeding, pack into the peritoneal cavity all round the incision some sterile gauze. I use a long roll of gauze, so as to prevent losing sponges. I am not afraid of the liquor amnii running into it, for this fluid is an aseptic saline fluid. Then you make the incision into the uterine wall; making a four-inch incision into the wall. Some make a transverse incision, from which they say they get less hæmorrhage. Never mind about the placenta. If the woman is not in labour the amnion is intact; you can see the membrane, you can cut through it with the knife, slip your fingers in and seize the foot or knee, or hook your finger round the groin, and pull the child out breech first. Some books say that if it is a breech

presentation you should bring the head up first. I do not agree with that; if it is a breech case it is easier to get the knee. If it is an ordinary head case you will have no difficulty: you pass your hand through the wound in the uterine wall and feel for a knee or foot, and pull it out. If it is a hand, put it back, pull the breech up and draw it through the wound, and then the head will come. If you find the cord round the neck, as it was in one of my cases, snip it through with scissors. We had our child out twenty seconds from the start of the operation. You hand the child over to one assistant, and you and the other assistant attend to the uterus. As soon as the liquor amnii came out, the uterus shrank, and it shrank still more when the child came out, until it was so small it was capable of being pulled through the abdominal wound, and my assistant and I could have controlled the hæmorrhage, if it had been required, by digital compression of the broad ligaments. But it is not necessary or advisable to draw the uterus through the abdominal wound before the placenta has been removed.

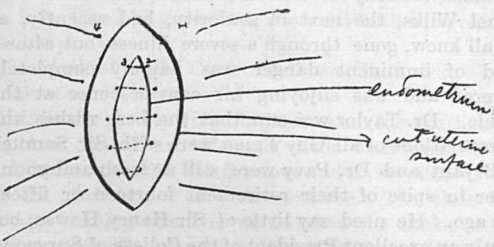
As a rule, when you have cut through the cord and some one has taken the child, you can easily and rapidly detach and remove the placenta. Where there is little hæmorrhage I often wait a few minutes watching the uterus contract and shrink in its size. In both these cases the placenta was in front, and you saw me rapidly detach it until I reached the amnion, which I ruptured with my fingers in order to get at the foot or knee of the child which I seized and drew through quite regardless of the placenta. This is by far the best plan. If you cut through the placenta and then drag the child out you will *tear* the placenta from its attachments, and *tearing* it away from the uterine wall is much more likely to be followed by hæmorrhage than detaching it gently with the fingers. By detaching the placenta rapidly and drawing the child out quickly you succeed in getting a living child, and the withdrawal of the child permits the uterus to contract so much that it stops the hæmorrhage from the uterine sinuses. The placenta and membranes being removed, you will find the uterus now so small that it can be drawn forward through the abdominal wound and manipulated at pleasure. The hæmorrhage can be controlled by the assistant grasping the lower ends of the broad ligaments where the uterine vessels are, though this is as a rule quite unnecessary, and when the bleeding is not much we do not resort to this measure. The assistant grasps the cut surfaces of the uterus and if there are any vessels bleeding on the cut surfaces, or at the endometrial edges, these are seized with catch forceps and if need be (though this is very rarely necessary) tied with ligatures. It is very necessary to be rapid in your operation and not to lose your head. The hæmorrhage in some cases appears to be enormous and is appalling, but the best means of overcoming it is rapid delivery in order to get the uterus contracted.

Some authorities advocate the introduction of some gauze into the uterine cavity, pushing it down into the vagina through the cervical canal, so as to constitute a drain. I do nothing of the sort. Of what use is it there? Is there not a good drain? Did you ever find a cervical canal which did not drain from the uterus well enough at and still better beyond the seventh month of pregnancy? You can get your finger in easily at the seventh month or beyond, and thereforeit is easy for the fluid to come out.

Next comes the sewing up of the uterus. This should be done without delay, because when it is completed the uterine muscular fibres are able to contract almost as well as before the wall was cut, and so post-partum hæmorrhage is rendered much less likely. Sänger's modification was sewing up the wound in the uterine walls with ligatures passed in the usual way, and then drawing the peritoneum over the wound by a series of Lembert's sutures. When asepsis was not quite perfect such a method was superior to others. But now it is found to be unnecessary, and as it takes a considerable time it has been abandoned by most operators. All you have to do is to bring the cut surfaces into apposition. Therefore sew up the uterine wall in the ordinary way. Some people prefer catgut, but I use silk, because you cannot boil catgut and render it quite aseptic. Catgut can of course be kept in strong carbolic, but I am not satisfied with that, as the carbolic does not penetrate to the centre. I use No. 4 Chinese twist silk, which I thoroughly boil and keep in alcohol. There is nothing more important to the medical man than to have some aseptic sutures always ready. My silk sutures are wound on glass bobbins and kept in pure alcohol ready for use. When I want to use them I take them out of the alcohol and boil them again.

You suture in this way: The needle is inserted about three-quarters of an inch from the cut edge of the uterus and passed through the uterine wall so as to emerge close to but not through the endometrium; it is now carried across to the other side, entering the raw surface above the endometrium, pushed through the uterine wall so as to emerge on the peritoneal surface

FIG. 1.



The top suture is entered at 1, about half an inch from the cut edge, and penetrates obliquely so as to emerge at 2, close to but not through the endometrium, it crosses to 3, the corresponding point on the opposite side, and emerges at 4, about half an inch from the cut edge of the uterus. In the same way each of the other sutures are put in.

FIG. 2.

After the ligatures have been drawn tight and tied the ends are cut off close to the knots. If need be extra sutures can be put in at any point that seems to gape at all.

at a point three-quarters of an inch from the cut edge so as to correspond with the point of entrance on the other side.

About five such sutures are inserted and they are now tied securely and the ends cut short.

If you saw that the bleeding was rather severe or that any artery was bleeding, I think it would be justifiable to run the needle through that and tie it separately before you start your suturing. I have never had to do that. One operator in London had a death on the table; he could not stop the bleeding. If after suturing you see any gaping, put an extra one in. Never mind the peritoneum coming over it. One reason, however, is urged for putting Lembert sutures in, and that is that there is then less liability of adherence of the uterine wall to the abdomen, so that you can adopt it if you like. You can then sterilize your patient if you think proper. The most certain way is to remove the ovaries. What we do, however, is to simply remove the middle portion of the Fallopian tubes on each side, and then invert the cut end and sew the peritoneum over. It is said that pregnancy follows in some of these cases. If it does it is a very rare event, and I think the woman might well take that risk seeing she has her ovaries left. Of course, removal of ovaries absolutely prevents pregnancy.

Some people recommend thorough douching and washing out and sterilizing the vagina before starting. I do nothing of the sort. The vagina is sterile as a rule, and the secretion of the cervix uteri is antiseptic.

Another point is, How do you deal with hæmorrhage in Cæsarean section? Just as you do in ordinary labour. You might pour hot water into the uterus, but we have never had to do that yet. I like to get the uterus sewn up as quickly as I can. The fibres can contract and stop the bleeding, and if there is bleeding subsequently I say to my assistant, Just deal with it as you would with ordinary post-partum hæmorrhage, viz., grasp and knead the uterus through the abdomen and give a hot douche at 120° per vaginam. If you had seen these patients I have spoken of in the ward you would not have known they had been through anything but an ordinary labour. I hope you will feel ready for cases of Cæsarean section when you get into practice. The operation will enable you to ensure a living child in most cases. Of course, in country places you may not be able to get every assistance you require, but if you get a man who understands the importance of having everything aseptic, and if you have sterilized sutures and gauze always ready, you will find you can do this operation as well as, or better than, that of sewing up the perinæum. But you must not lose your head, and must be able to deal with hæmorrhage without getting frightened.

NOTE.—Since the above lecture was delivered the second patient has had her uterus removed by vaginal hysterectomy. The only point about the operation that was specially noteworthy was the extreme friability of the body and fundus of the uterus where there was no cancer, this being limited entirely to the cervix. This friability was no doubt caused by the fatty degeneration of the involuting process. The patient made an excellent recovery and left the hospital in good condition. She weaned her baby just before she came in. The uterus exhibits some points of interest which I hope to work out later on.

The Biennial Dinner.

THE Guy's Hospital Biennial Dinner, which took place in the Whitehall Rooms, Hotel Metropole, on Tuesday, July 5th, was a most successful occasion. Those who sat down to dinner numbered 202 and consisted of men of all years from those whose student days were spent here a quarter of a century ago down to junior men of the present day. Mr. Clement Lucas, who occupied the chair, having dealt in a few words with the loyal toasts, which were duly honoured, made the first of a series of particularly interesting speeches by proposing the toast of "Prosperity to Guy's Hospital and its Medical School."

Mr. LUCAS (who was greeted with loud applause), spoke of the inter-dependance of the hospital and the medical school, and alluded to the mighty men of old time who had helped to make Guy's the honoured institution that it now is—Addison, Astley Cooper, Babbington, Cock, Hilton, Braxton-Hicks, Gull and Moxon were patriarchs whose discoveries had enriched medical science and cast a reflected glory on the hospital. Nor were we without our honoured names to-day, and prominent amongst these he would put the names of five Guy's men all of whom had received the distinction of knighthood during the past two years—Sir Cooper Perry, Sir Alfred Fripp, Sir Alan Manby, Sir Thomas Stevenson and Sir Constantine Holman. He had been asked by the Dean to refrain from any reference to the annual report, that many of them would listen to on the morrow (Prize-Day), but he would say just this, that the hospital was as flourishing as it ever had been and it was a *united* hospital. There had been differences in the past—serious differences in fact—but these were all forgotten now, and in their love of their Alma Mater Guy's men to-day presented a united front. He gave them the toast coupled with the name of Mr. Bonsor. (Loud cheers).

Mr. COSMO BONSOR, who was most enthusiastically received, thanked Mr. Lucas for the eloquent manner in which he had proposed the toast. Guy's was well worthy of their enthusiasm, its respectability was overpowering, for it had been in debt for eighteen months, and that debt was not increasing! He complained somewhat that he should have been designated on the toast list as an M.P. He was not an M.P., and had not been for some years. Only that afternoon he had had occasion to thank heaven that he was not still a member of the august body, when from the visitors' gallery he had listened to the efforts of a medical man who had not expressed the opinion of his electorate for fully eighteen months, and had at last dared to venture on a speech which must have been, as Mr. Speaker pointed out, as many months old.

Mr. Bonsor's speech was heartily applauded, and at its conclusion the company joined hands in singing "Auld Lang Syne."

Dr. FREDERICK TAYLOR next proposed the toast of the Consulting Staff, which now numbered eleven members. Mr. John Birkett retired in 1876, and though up to a few years ago he had been acti e, r ght and energetic, he had more recently become a confirmed invalid.* Sir Samuel Wilks, the next in seniority, had recently, as they all knew, gone through a severe illness, but after a period of imminent danger was happily completely recovered and was enjoying his convalescence at the sea-side. Dr. Taylor was sure that the best wishes and congratulations of all Guy's men were with Sir Samuel. Mr. Bryant and Dr. Pavy were still as fresh and young as ever in spite of their retirement fourteen or fifteen years ago. He need say little of Sir Henry Howse, but recently an excellent President of the College of Surgeons, and of Dr. Goodhart, whose early retirement from pressure of private work was a sad loss to the School; of Dr. Savage, Dr. Galabin, Mr. Tom Bird and Mr. Purves, each of them holding a leading position in his especial department—all these were names too well known to such an audience for them to require any further mention on his part. Dr. Pye-Smith he alluded to as a distinguished and learned physician, Vice-Chancellor and the active head of the University of London, an accomplished writer to whom we owe the perpetuation of Fagge's well-known work on medicine, and a delightful after-dinner orator. With these members of the Consulting Staff he associated the names of two teachers in the Medical School who were present amongst them, Dr. Debus, who retired several years ago, a brilliant lecturer in Chemistry, and Mr. Groves, his able successor in the same subject. Dr. Pye-Smith was asked to respond to the toast.

Dr. PYE-SMITH, in replying, also referred to the great names of the past, and of these he said he considered Addison's perhaps the greatest. He well remembered the latter's lectures, and spoke of his forbearance in dealing with the mistakes of those less gifted than himself. "He never made capital out of other men's mistakes." He (Dr. Pye-Smith) had dressed to Hilton, and he related several amusing incidents in connection with that surgeon. There were many stories that he could tell but time forbade him, all of these would however testify to the love of Guy's men for their hospital and to their industry and generosity.

To Mr. LANE fell the pleasant task of proposing the health of the Chairman, and he accomplished the same in his most characteristic manner. He deprecated the tendency of previous speakers to harp upon the past; he was sick of the past; it did not interest him in the least. The present and the future were far more important to his mind, and he believed that Guy's could and would turn out men every bit as good as the best that had been mentioned by other speakers. He spoke of the association of his earliest memories of the hospital with the name of Mr. Lucas. The latter was an anatomy demonstrator when first he met him, and was noted for his way of worrying men to go up for exams. that they did not want to go up for. But if he differed from men in his opinion as to their capabilities, events had generally proved him to have been right.

*We regret to chronicle elsewhere the death of Mr. Birkett, which occurred on the following day.

Mr. Lucas's energy in these days was untiring, and he had ever been as staunch a supporter of sport as of work. His own position he felt he owed directly to Mr. Lucas, and he gave them the toast with the greatest possible pleasure.

The toast of "The Chairman" was then drunk with acclamation.

Mr. LUCAS in replying thanked them for the honour they had done him. He had made discoveries in his time, but he thought his greatest and most valuable one was his discovery of Arbuthnot Lane. The time was fast approaching when he would leave the ranks of the visiting surgical staff, and he hoped it would be said of him that he had never dwarfed any genius, never refused a new theory without a trial, never failed in his attempts to leave better men behind him. (Cheers.) He reminded the company of the thanks that were due to Dr. Pitt for the excellent arrangements of the dinner. (Renewed cheers.)

Dr. PITT thanked them for their kind reception of his name. He hoped they were all satisfied with the seating. It was a difficult matter sometimes to seat old friends together when they did not give him sufficient notice. He thought that perhaps a good arrangement in the future would be for the men of the same decades to make a point of being present at particular dinners. The men of the 'eighties, for instance, on one occasion and the men of the 'nineties on another: the plan was not of course to exclude men of other years, but was merely meant to ensure the meeting of men of the particular decade in question.

Before the official proceedings terminated, Mr. Lucas read the following telegram from Sir Samuel Wilks, "Sorry cannot come to meet my friends to show living specimen of wisdom and skill of Guy's men. Give them all assurance of my affection and regard."

With this the more informal part of the evening began, and concluded very pleasantly in conversation.

Papers by Guy's Men.

Accidental Vaccinia of the Nasal Cavity. By W. H. Bowen, M.B., B.S. Lond., F.R.C.S. Eng.—*The Lancet*, 2nd July.

The Mode of Infection in Tuberculosis. By J. M. Fortescue-Brickdale, M.D. Oxon.—*Ibid.*

The Causation, Diagnosis and Treatment of Perforating Ulcer in Typhoid Fever. By E. W. Goodall, M.D. Lond.—*Ibid.*

On Diabetic Neuritis. By F. W. Pavy, M.D. Lond., LL.D. Glasg., F.R.S.—*Ibid.* and 9th July.

Pneumococcal Appendicitis and Pneumococcal Peritonitis. By Lauriston Shaw, M.D. Lond., F.R.C.P., and Herbert French, M.D., B.Ch. Oxon.—*British Medical Journal*, 2nd July.

Traumatism and Hernia. By William Sheen, M.S., F.R.C.S.—*Ibid.*, 9th July.

Two Records from the Post-mortem Room. By George Mahomed, M.R.C.S.—*Ibid.*

Prize Day.

WEDNESDAY, JULY 6TH, 1904.

FORTUNE certainly favoured us with the choicest of summer days for the Annual Garden Party and Distribution of Prizes by the Right Honourable the Viscount Goschen, Oxford's recently elected Chancellor.

Not a single cloud obscured the prevailing blue. The sun shone brightly, while a cooling breeze tempered its intensity and left nothing to be desired, despite the gloomy promise of the preceding days.

Dressed in its best, and resplendent with new paint, fresh flowers and bunting of varied hue, the whole being set off to great advantage by the almost tropical sun, our Hospital could not have appeared under more pleasing circumstances. The two quadrangles on either side of the colonnade were, for the time being, converted into pleasure gardens where, at the appointed hour, choice refreshments abounded. The park seemed greener and fresher than ever amidst its sombre surroundings, and its welcome shade was utilised to the utmost. In spite of the counter attractions afforded by Royal visitants and the special ceremony at St. Bartholomew's, and a corresponding lack of any exceptional event of interest, such as the opening of the Raphael Nurses' Home and Wills Library of recent years, at Guy's, there was no falling off in numbers of those who attended the Garden Party.

Early in the afternoon the front quadrangle, colonnade and park assumed a most animated appearance. The medley of summer frocks, academic robes and nurses' uniforms providing a vivid though somewhat discordant picture.

Among those present—about 3000 in all—were the following distinguished visitors—Lord and Lady Cottesloe, General Sir Richard Harrison, the Bishop of Southwark and Lady Barbara Yeatman-Biggs, Surgeon General and Mrs. Beatson, Surgeon General Keogh, Mr. R. K. Causton, M.P., and Mrs. Causton, Sir Henry and Lady Norbury, Sir William and Lady Church, Dr. and Mrs. Allchin, Canon Rhodes Bristow, the Mayor and Mayoress of Southwark, the Mayor and Mayoress of Bermondsey, Mr. Alderman Crosby, M.D., Mr. Under Sheriff Timbrell, Mr. H. Beerbohm Tree, Mr. Alderman and Mrs. Strong, Mr. and Mrs. M. Trevelyan Martin, Mr. Robert Gordon, the Hon. Mrs. Talbot, Sir Joseph and Lady Savory, Mr. H. A. Harben, Mr. W. Raphael, the Rev. J. Scott Lidgett, Lady Crawford, the Prime Warden of the Dyers' Company, the Masters of the Cordwainers', Ironmongers', and Armourers and Brasiers' Companies, and the Governors of the Hospital, with Members of the Medical and Surgical Staff.

At three o'clock Lord Goschen drove up, accompanied by Lady Evelyn and the Hon. E. J. Goschen. He was received in the Court Room by the Governors and Senior Staff of the Hospital. The company immediately proceeded to the Physiological Theatre, which was already crowded to its utmost limits by an expectant audience.

Mr. Cosmo Bonsor, our Treasurer, presiding, was seated to the left hand, and the Dean to the right of his lordship, the rest of the platform being occupied by the Governors and robed Staff. Mr. Cosmo Bonsor opened the meeting.

The CHAIRMAN:—My lord, ladies, and gentlemen, I think to-day we may congratulate ourselves on two events. In the first place, like Englishmen, on the weather. The weather is all that it should be. And in the second place, we have to congratulate ourselves very much that we have at last secured Viscount Goschen, Chancellor of the University of Oxford, to come amongst us, and, I believe for the first time since his inauguration, to address a body of students and those interested in education. I will now call upon the Dean to read his annual report.

DEAN'S REPORT, 1903–4:—

The progress of the School during the last year, though uneventful, has been very satisfactory and encouraging. The successes at the different examinations, especially those of the University of London, maintain their usual high level, and are such that the School must cordially congratulate both Teachers and Students.

At the Preliminary Scientific and Intermediate M.B. Lond. Examinations the number of successful candidates has been quite satisfactory, considering the temporary conditions of the tests, and in the later Examinations the percentage of passes remains as high as in previous years. We have to congratulate Dr. Harold Nolan most heartily on his success in obtaining the Gold Medal in State Medicine at the M.D. Examination of the University of London, and Dr. W. M. Robson and Mr. R. P. Rowlands, the former having qualified for the Gold Medal in the M.D. and the latter for the Gold Medal in the M.S. Examinations, both in November, 1903. The University qualifications obtained by Guy's men since this time last year are as follows:—

At the London University 10 men graduated as Doctor of Medicine, 2 as Master in Surgery, and 25 graduated as Bachelors of Medicine. At Oxford, 2 men obtained their M.B., and 2 their M.D. degrees. At the University of Cambridge, 8 Guy's men have, during the year, completed the Final Examination for the M.B., B.C. Other University degrees and higher diplomas of the College of Surgeons and College of Physicians, amounting in all to 9, have been obtained by other Guy's men during the year. Excluding all University degrees, no less than 60 students from Guy's Hospital have obtained diplomas granted by the Royal College of Surgeons and other Bodies entitling them to practice. During the year also 9 Guy's men have obtained a commission in the Royal Army Medical Corps, 6 have obtained a commission in the Royal Naval Medical Service, 2 have entered the Indian Medical Service, and 3 Dental men have been appointed Civilian Dentists to the Army for a period of one year.

These figures are given, not with an idea of comparing in any way with other institutions, or past years, but simply as an illustration of the way in which the Medical School, while assisting the Hospital on this spot, serves the cause of the community over a much wider area by distributing fully qualified and competent medical men all over the world.

With reference to the Army Medical Service, we are happy to state that the re-organisation of the Army Medical Corps and the increased attractions provided by that Service have been very successful in drawing from this Hospital some of our best and most promising students.

In the Dental School the high standard of teaching has been maintained, and successes at the L.D.S. Examination have been most encouraging. Thirty-eight students have completed the final Examination for the L.D.S. Eng., during the course of the year.

With regard to the changes on the Hospital and School Staff, I have to announce that with the exception of two resignations from the Dental Staff, the Staff of the Hospital and School has suffered no loss during the year. Mr. Tom Bird's resignation of his post as Instructor of Anæsthetics was announced in July last, and it remains to be stated that Mr. George Rowell has been appointed Lecturer on Anæsthetics in his place. During the past year the administration of Anæsthetics has received the serious attention of the Governors of the Hospital. It is now incumbent upon all candidates for the Diploma of the M.R.C.S., L.R.C.P. Eng., to obtain a Certificate of proficiency in the administration of Anæsthetics. With this end in view, the Governors have appointed five additional Anæsthetists to the Hospital—Drs. Forsyth and Levy; Messrs. Ormond, Turner, and Hicks. The total number of Anæsthetists on the Hospital Staff is now eight, and a scheme is in operation whereby the Medical School and Hospital can give adequate instruction in Anæsthetics to close upon one hundred students yearly. As the giving of Anæsthetics is by no means the least important or responsible part of a Practitioner's duty, either at the Hospital or in private practice, it is felt that this new arrangement tends to render all men qualified from this Hospital more competent in this branch of medicine.

I have to announce with great regret the fact that during the year Dr. Fawcett has found it necessary to resign his Deanship. His loss from that office has been deeply felt by the Members of the Hospital and School Staff, and they desire to express the most hearty appreciation of his labours as Dean during the last four years.

Subsequent to his resignation, Dr. Fawcett has been appointed Curator of the Museum.

In order to prepare Cambridge Students for a new part of their medical curriculum, courses of study in Pharmacology and General Pathology have been instituted, and Dr. A. P. Beddard has been appointed Demonstrator of General Pathology, with Dr. Spriggs as Demonstrator of Pharmacology.

Sir Cooper Perry has during the year resigned his Lectureship on Materia Medica, and Dr. Bryant has been appointed to succeed him, Dr. A. P. Beddard being appointed Demonstrator of Morbid Anatomy to succeed Dr. Bryant in that office.

During the year Mr. Graham Simpson resigned the post of Surgical Registrar to the Hospital in order to take up a provincial Surgical Appointment, and Mr. A. R. Thompson has been appointed Registrar in his stead.

More recently, Mr. Arbuthnot Lane has relinquished the post of Lecturer on Anatomy, and Sir Alfred Fripp has been appointed to fill the vacancy.

Of the Dental Staff, I regret to announce that Mr. Badcock has been compelled by pressure of other work to resign his post as Dental Surgeon. Mr. Badcock has been on the Dental Staff for many years, and his loss will be most keenly felt by his colleagues, and the whole of the Dental School.

Mr. Wynne Rouw has been appointed Dental Surgeon in his place, Mr. J. L. Payne being appointed Assistant Dental Surgeon to fill the vacancy on the Assistant Staff.

To the great regret of the Dental School, Mr. Newland-Pedley has resigned his post of Lecturer on Dental Surgery, which he has held for the last fifteen years, but it is with great pleasure that the Dental School understand that Mr. Newland-Pedley will still continue his duties as Senior Dental Surgeon. To fill the vacancy caused by these changes, Mr. Wynne Rouw has been appointed Lecturer on Dental Surgery, Mr. Parfitt Lecturer on Operative Dental Surgery, and Mr. Payne Lecturer on Dental Mechanics.

The Dental School also has to regret the resignation by Mr. F. W. Cock of his position as Anæsthetist to the Dental School, a post which he also has held for fifteen years. The Dental Staff desire to place on record their best thanks to him for the very valuable work he has done during that period.

It was announced in last year's report that Dr. Ainley Walker, the Gordon Lecturer on Experimental Pathology, had been elected to an official Fellowship at the University College, Oxford. I have to announce that Dr. A. E. Boycott has been appointed Gordon Lecturer in his place.

During the year the Governors have created a new appointment to provide for the development of treatment of Lupus, Cancer, and other diseases by Light Rays, and Mr. Gerald Sichel has been appointed the first Surgeon in charge of the Actino-Therapeutic Department. The necessary apparatus is being installed in suitable quarters in the Surgical Buildings, and treatment will shortly be commenced.

It is with great pleasure that we have to state that there have been no changes on the Consulting Staff during the present year, and everybody will join in congratulating Sir Samuel Wilks on his recovery from a very serious illness.

In connection with the recent alterations and improvements in the School Buildings, I have to announce one or two important donations. During the course of the year, the Rt. Hon. A. J. Balfour has forwarded to the Treasurer of the Hospital a sum of £30 towards the Medical School Research Fund. The School has a double debt of gratitude to pay to Mr. Balfour, as some years ago on a similar occasion to this he made on behalf of this Research Fund a speech which was remarkable not only for its grasp of the subject and its breadth of view, but also for being, I believe, unique as a commendation of scientific research from the lips of a leading politician. In the Hospital Report of last year it was announced that the most pressing need of the Medical School was a sum of money to enable it to at once proceed with the building of a Museum which should adequately house the great collection of pathological specimens at Guy's. During the past few months the Medical School has received, with the deepest gratitude, a promise, from a donor who has hitherto wished to remain anonymous, to build the Museum. On this occasion I am pleased to be able to announce that our benefactor is a Governor of the Hospital, Mr. Robert Gordon, who has previously in many and generous ways shown his interest in the Medical School. The work of building the Gordon Museum is well in hand, and I hope that before this time next year it will be ready for opening. Stimulated by this munificent donation, the Staff of the Hospital and Medical School have determined to proceed with the building of a new Lecture Theatre and Class Rooms adjoining the Gordon Museum in order that the old block of buildings in which these Class Rooms and Museum were housed can be pulled down, and so provide a most necessary addition to the limited garden space available for children and convalescent patients.

The wisdom of the Medical School Staff during the past years in spending large sums of money in building the College, the new Chemical Laboratories, and the new Physiological and other School Buildings is just beginning to bear fruit. Although the curricula of the London University and of the College of Surgeons and College of Physicians have recently been altered and in some respects increased in scope, I am glad to say that this School is now so adequately equipped to deal with Medical Education, and with a number of students larger even than we have, that in order to deal with these increased courses of study, it has not been found necessary to increase the size of a single Laboratory, or the Staff by a single Demonstrator.

Finally, I have to congratulate the Senior Member of the Medical School, and a very old servant of the Government, on a recent and well-earned distinction. I refer to Dr. Thomas Stevenson, upon whom the King has within the last month intimated his intention of conferring the honour of a knighthood. Sir Thomas Stevenson has been a Member of the Medical School since 1866, and is the oldest and most honoured Member of that Staff. His services to the Government and the Nation at large have been performed quietly for thirty years in the Home Office as Public Analyst, and during that time he has done some of the most valuable scientific work in Toxicology which has been performed during this generation. The Staff of the Hospital and the Medical School offers Sir Thomas Stevenson its most hearty congratulations and thanks for the work he has done, and adds to it the wish that he may for a long

time continue to be associated with the Hospital and School.

The CHAIRMAN :—I will now ask Viscount Goschen to be good enough to give away the prizes.

Mr. EASON then commenced to call the names of successful competitors—Entrance Scholars, Medallists, and Prizemen—each of whom received his reward from the hand of Viscount Goschen amid hearty applause.

The following is the list of successes :—

OPEN SCHOLARSHIPS IN ARTS.—Sydney John Darke, Owen's School, Islington, £100. Jean René Perdrau, Royal College, Mauritius, £50. Guy Barton Cockrem, King's School, Canterbury, Certificate.

OPEN SCHOLARSHIPS IN SCIENCE.—Harry Archibald Sanford, Guy's Hospital, £150. Leonard Tilsley Baker, Dulwich College, £60. William Johnson, Guy's Hospital, Vincent Townrow, University College, Sheffield, equal Certificates.

SCHOLARSHIP FOR UNIVERSITY STUDENTS.—Charles William Greene, Emmanuel College, Cambridge, £50.

OPEN SCHOLARSHIPS IN DENTAL MECHANICS.—October, 1903, Robert Charles Basker Shaw, £20; May, 1904, George Packham, £20.

JUNIOR PROFICIENCY PRIZES.—Kenelm Hutchinson Digby, £20. Ernest William Giesen, £15. Thomas Edmund Ashdown Carr, £10. George French Stebbing, Certificate.

THE MICHAEL HARRIS PRIZE FOR ANATOMY.—Kenelm Hutchinson Digby, £10.

THE SANDS-COX SCHOLARSHIP IN PHYSIOLOGY.—Ernest William Giesen, £15. Kenelm Hutchinson Digby, Certificate.

THE HILTON PRIZE FOR DISSECTIONS (1903).—Patrick Francis McEvedy, £3. William Henry Millar, £1. William Henry Trethowan, £1. (1904) Kenelm Hutchinson Digby, £1 13s. 4d. Ernest William Giesen, £1 13s. 4d. Christian Hugo Rippman, £1 13s. 4d.

THE ARTHUR DURHAM PRIZES FOR DISSECTION.—First Year's Students. — Edward Leslie Martyn Lobb, £5. Thomas Stansfield, Certificate. William Johnson, Certificate. Howard Bernard Carter, Certificate. Senior Students.—Ernest William Giesen, £15.

DENTAL PRIZES. — First Year's Students. — Robert Charles Basker Shaw, £10. Arthur William Parrott, Certificate. Practical Dentistry Prize.—James William Mawer, £10. Julian Bollard, Certificate. Travelling Dental Scholarship.—John Edmund Spiller, £100.

THE BEANEY PRIZE FOR PATHOLOGY (1903).—Neville Ivens Spriggs, £34.

THE TREASURER'S GOLD MEDAL FOR CLINICAL MEDICINE.—Arthur Frederick Hertz.

THE TREASURER'S GOLD MEDAL FOR CLINICAL SURGERY.—Arthur Frederick Hertz.

THE GOLDING-BIRD MEDAL AND SCHOLARSHIP IN BACTERIOLOGY.—Charles Morley Wenyon, £20. Maurice George Louisson, Certificate.

After the completion of this ceremony, the chairman invited his lordship to address the prize winners and assembled company.

Viscount GOSCHEN, who was very cordially greeted on rising, said :—Ladies and gentlemen—The first question which I ask myself is, why am I here, not being a scientific man, and not being able to address you on medicine or surgery. I am here, I think, in the first place, because Mr. Bonsor asked me to come (laughter), and I find a difficulty in refusing Mr. Bonsor. In the next place, I am here because my son is a governor of the Hospital, and he has spoken to me of its fine work and the interest which is taken in it. And in the third place, ladies and gentlemen, I have been, in the course of my administrative career, connected with hospitals. I think it is now some thirty or more years ago when I was at a Department which was then called the Poor-Law Department, and I at that time had a great deal to do with the administration of hospitals for the poor. And it is not uninteresting to me sometimes to look back to those times and to contemplate the enormous advance in the hospitals, in treatment, in knowledge, and in science, since those days, during the comparatively short period of thirty-five years. I wonder whether all the questions that were being debated at that time, and which troubled me very much as a layman, have been laid to rest since. For instance, there was the question of ventilation, the ventilation of hospitals; and I had the misfortune to have advisers who differed fundamentally among themselves as to the principles of ventilation. And this surprised me, because, as a layman, I thought that science must be able to determine such questions as those absolutely; that it was not a question of certain men being half right and half wrong, but that there must be some fundamental principle of ventilation which it was their business to discover, and then, by unanimous opinion, to force it upon the President of the Poor-Law Board. Whether in later days that question has been solved entirely to the satisfaction of scientific men I do not know, but I fear it has not been entirely settled to the satisfaction of patients (laughter), because in every hospital that I have entered there have been constant complaints from the patients as to the scientific method of ventilation which keeps them in ill-health (laughter). I came back to hospital work when I was at the Admiralty, not so very long ago, and therefore I was able to see the progress which had been made, the splendid buildings which are now thought necessary for the accommodation of the sick, the improvement in every department of science, and the improvement above all, perhaps I may say, in the standard of the ideal up to which the medical profession require the administrators to go. (Applause.) I mention those matters to show you I have taken some interest in hospitals. But I do not propose, in the few moments during which I will detain you, to deal with the question of hospitals, or with their finance, or with some of those burning questions such as whether the hospitals should be put upon the rates—a very burning question, and one which, if solved, might possibly ease the administration of the hospitals, but would shut up many founts of sympathy and charity the keeping open of which operates well, I think, upon the general temper and tone and character of the

population. (Applause.) But I wish to address a few words to the students, and to the prize-winners especially. They have gone through successful examinations, but I should like, if it were possible for me to do so, to cross-examine them upon some points myself. (Laughter.) I should like to know what dreams they are dreaming. Of course they have ambitions, of course they have goals towards which they wish to strive, but I should like to know in what direction their ambitions lie, what is the goal of their hopes. No doubt as nearly everyone who enters the Church hopes that he will be a bishop, if not an archbishop, as everyone who enters the law hopes he may be Lord Chancellor, so, no doubt, those who enter the medical profession, and especially those who win prizes, see before them the fulfilment of some great ambition and the opening out of some useful and satisfactory career. Now, what career? In what direction do the prize-winners at large see hope? In what direction do they see the satisfaction of their desire for work? Of course I do not say they desire to be presidents of the great surgical and medical institutions, but apart from that they see in their mind's eye a fine West End practice with a waiting-room full of fair women and patient gentlemen (laughter), while in their own room they are raking in the bi-metallic guineas (laughter), a sum composed of both silver and gold—the golden sovereign and the modest useful shilling by its side. Or do they see the hope and the prospect of fame in great discoveries in the papers which they will write and for which foreign academies are waiting with scientific avidity? (Laughter.) Or do they see a prospect opening out to them, vast and useful, in the fighting of disease in the thickest parts of the large towns, in meeting epidemics, and making their names as the subduers of disease in the splendid fight? In a word, are they for research or are they for practice? Do they aspire to have the genius of the bedside or the genius of the laboratory? Do they go for knowledge and science or do they go for the practice of the healing art? No doubt some will go in one direction and some will go in another, and the good wishes of their fellow-students will accompany them in whichever of those directions they will go, for in them there is fine and noble work before them. As regards research, ladies and gentlemen, the Dean has alluded to a speech which was made by Mr. Balfour some time ago in which he pleaded the cause of research most eloquently and most successfully. The country desires research. Everyone must admire the splendid progress which has been made in research; everyone knows how much there still remains to be done, the vast area which has still to be opened up. And perhaps in no department of science or medicine has larger and greater progress been made than in that of research. I have a passage here from Bacon which shows what he thought of the knowledge of science in its efforts towards study in those days: "Medicine is a science which has been more professed than laboured, and more laboured than advanced, the labour being more in a circle than in progression. I find much iteration, but little addition." How surprised the men of science of those days would be if they were to see, not the iteration, but now the constant progress, progress forward, and the additions to science which almost every year brings with it. And the cause to which Bacon attributed the moving of science in a circle was, that there was "a want of the ancient and serious diligence of Hippocrates." Hippocrates finds his rival in the scientists of to-day. At a later period there is a story told by, I think, Dr. Brown, of an old French physician at four successive stages: "At 20 I was dogmatic," he said; "at 30 I was an observer; at 40 I was empiric, and at 50 I found myself with no system at all." I do not think that is necessarily the progressive story of a medical man at the present day, except in the beginning. Of course, all young men are dogmatic—that has been so throughout all ages, and I believe it will always be. But we have the observers now, and they have a system; that system exists, and one can see what enormous progress has been made in that respect. Yes, the country demands research, it requires study, it requires the opening up of the nebulous and mysterious hinterland which lies behind the present explored province of medical science. The nation clamours for new discoveries, being stimulated to the belief that new discoveries will come by the rapidity with which some of the last discoveries have been made. And so research will claim its votaries, research will open the purse-strings of the country, perhaps more than any other department of physical science, because the nation feels distinctly the need for progress in meeting some of the terrible diseases which afflict us. But you cannot all be researchers, you cannot all even be specialists; and even in what I may call this Temple of Science, at the very altars of research here at Guy's, and in the presence of so many of its votaries, let me say that we must also consider the general requirement of the nation to have an army of doctors—competent, scientific, energetic doctors—spread in every corner of the land. And it is the duty of Guy's and of the great hospitals to contribute regiments to that army, and I hope that Guy's will contribute a picked regiment of guards (applause), having all the noble traditions of the place in which they have been brought up, and in that way they will spread over the land. I am told that now the great majority—Why should I not tell the truth as I hear it? Though I hope it is not the truth, but you will be able to correct it if it is not—I am told there is a strong tendency amongst the young medical men of to-day to incline exclusively towards research, and if not to research, then to the highest forms of specialism. That would be a misfortune, in many ways, for the country, because the country requires professors in the art of healing as well as students of science. There was a saying forty years ago—again, I think by Dr. Brown—that at that time the art of healing was suffering while men were mastering science. However that may be, there must not only be specialization, there must not only be specialists, but there

must be general practitioners. (Hear, hear.) General practitioners: let not the term be despised. Every country village wants a competent doctor, and if there is no competent doctor in the village there may be untold suffering, there may be misery in many a home; there may be many blighted lives. And let no one think that a general practitioner in the country does not mean an honourable profession of the art of medicine and surgery. (Applause.) I hear rumours, too, that the family physician will go out of fashion; that as men incline to specialism they like to go to some place where they will be specialists, where they will be consulted; they want to be, at an early age, consulting physicians. I hope the family physician will not entirely vanish from amongst us; men like to have a family physician, they like a man who has got, if I may say so, a map of their interior, who has got statistical diagrams of all the movements of their heart, of their pulses, and so forth. They like that, and I am not sure, with regard to dentistry, that if a man comes to tell me there is a famous dentist who has come to London and I ought to consult him, that I would consult him. I say no, I prefer to go to the dentist to whom every tooth in my mouth is an old and intimate friend. (Laughter.) Well, ladies and gentlemen, I have spoken about country practices, I have spoken of the family physician, but I have said little, though I feel much and think much, of the men on whom I have just touched, men who have to fight the battles of the poor, who have to go amongst them in the East End, who have to carry their lives almost in their hands, to meet the frightful diseases which they may have to encounter. Theirs, too, is a noble profession, and the work they have to do is noble. The art is noble, and if one may judge from other things, a noble art requires noble qualifications. What are those qualifications? A doctor requires gentleness, gentlemanliness (hear, hear), honesty, sympathy, all those qualities, as well as the skilful hand, the scientific mind, and the penetrating eye. He requires all those qualities, he requires their combination; and it is not so easy to maintain all those qualities, that sympathy, that belief in human nature which I think ought never to be absent from a doctor's mind. It is difficult, perhaps, to maintain them in the face of two dangers, which, if I am not mistaken, beset the doctor; an intellectual danger, and a moral danger. The intellectual danger is this: that he is dealing from his earliest time of his education and work in this Hospital, with hard physical facts, with material facts, with the material aspects of nature. and with causes and their results, all traced down by the most inexorable laws. And there may be some slight danger that he does not guard against these influences; a certain materialistic side may be developed in him, which would be much to be regretted, and which I believe would be better away, even in the execution of his practice, in the practice of his art. And the moral danger is this, it seems to me: that he is constantly in contact with the serious side of human nature; he constantly finds himself the confident of sin and of crime; he constantly finds himself dealing with diseases which are the result of crime and sin, drink and other vices. He sees their results. Is it too much to say that there are some who move in an atmosphere that might almost brutalize? That is their position; those are the dangers against which they must guard; and they must guard against them by trying to keep alive such spiritual promptings of their soul and their heart that they cannot be crushed down by the frightful sights they see. (Applause.) That is their duty. I would say to the medical students, Do not go through life as pessimists and cynics; do not let the pessimist devil ever whisper in your ear that all men and all women are bad, and none are good. (Applause). Keep up your faith in human nature; keep your belief that there are angels as well as beasts (applause), that there are angels and martyrs even among the suffering poor. And let the touching sights which you witness at the bedside sometimes, exercise a healing influence when you are dealing with the results of brutal violence and disgusting vice. That is what I would ask you; I would ask you amid all this to keep fresh your fount of sympathy. (Applause.) Let me sum it up in one word: Doctors require character, that combination of qualities which is well known by the name of character. And it is that character, besides your skill, besides your scientific and technical training which you will get in this hospital; it is that character which I hope you will carry forth from a place where the traditions are so high; and you will, I hope, always be able to remember in that sense all that Guy's has taught you. But not only that, not only as far as character is concerned. I have seen a passage from an address—I think it was by the famous Dr. Peter Latham, of St. Bartholomew's—an address which he gave to the students, in the following terms: "On entering this place, even this vast hospital, where there is many a significant, many a wonderful thing, you shall ask me to come along and I will be your guide; but it is by your own eyes, and your own ears, and your own minds, and, I may add, by your own hearts, that you must observe and learn and profit. I can only point to objects and say, See here, and see there." Those seem to be wise words. Remember it is not only eyes and ears. This passage means you must not only learn to imbibe and digest, but even this great physician spoke of the heart. You have a great insight into life and character, but the heart will teach you much, and may guide you in many a difficult case to read human motives, to even guide you to a diagnosis where the disease may not be entirely physical, and where a moral disease may exist side by side. Gentlemen, you will go forth on your mission, yes, *mission*. And that reminds me of a word. The Church sends out missionaries into the crowded parts of the metropolis and into our big towns; missionaries not only of religion, but missionaries of light and civilization. Let the hospitals send out missionaries of life and healing, with the same purposes, with the same noble objects of rendering service to their fellow creatures and their fellow townsmen. Let them go forward in that hope. While some cling with pertinacity and with noble devotion to the pursuit of wresting secrets from Nature which will be for the benefit of mankind, let others, with

equal enthusiasm, with equal will and equal ambition, devote themselves to the application of the knowledge which we have, and hold high that standard of honesty, sympathy and truth and knowledge which already adorns that great profession on the threshold of which you now stand. (Loud applause.)

Dr. TAYLOR, as senior physician, next proposed a vote of thanks to Viscount Goschen, he said: Ladies and gentlemen—It is my pleasant duty to invite you to pass a vote of thanks to the Right Hon. Viscount Goschen for his goodness in coming amongst us to-day and assisting at the annual distribution of prizes to our students. I am sure we all must be very thankful indeed to him for the way in which he has done it, and especially for the address which he has just given us (hear, hear), and the words of wisdom and advice which have fallen from his mouth. It is of very great value to ourselves and to our students that from time to time somebody should come before us and let us know the way in which others see us. A profession like this is very apt to be wrapped up in itself and sometimes it is useful to have its condition held up to us. Those three points which Lord Goschen referred to in his address are especially worthy of attention. He stated that the nation was eager for research. I am sure we are all very glad to hear it, and I quite think that many of those who have been before us as prizemen to-day will become researchers. And as research is desirable for the nation I am sure it can be done, only let it be remembered that the nation must pay. We have heard also his observations, as it were from outside, that there is a tendency amongst ourselves to drift away in certain directions and to neglect, so to say, certain other departments of work. I think that is an observation which has been made and that is no doubt somewhat true, but I think that at present, at any rate, there is no fear of the village being left unattended, or even the slum of London. There are plenty of practitioners passing their examinations, and there should be, in years to come, plenty of practitioners to do the work of the nation in every department as well as the work of empire all over the world. Then, ladies and gentlemen, I think we have to thank Lord Goschen for the advice he has given our students and our rising young medical men as to the course they should pursue and the qualifications which are necessary for a medical man. I can assure him and you that is the general tendency of the medical education in which he is engaged; and if the student studies at the hospitals for three to five years—some study six years—during that time those qualifications to which Lord Goschen referred are constantly developed and trained in him. Lord Goschen has shown us how much he knows of the medical profession, though he is not a member of it. He has told us that in past years he was in a position that gave him exceptional opportunities of becoming acquainted with a certain branch or kind of professional work. I may, in asking you to accord him a vote of thanks, remind you that the nation is indebted to Lord Goschen for his services over a long period of years in connection with the public services. (Applause). I do not know whether I can enumerate all the posts that Lord Goschen has held in the Government, but he has told us that he was President of the Poor Law Board. We have heard he was an Ambassador; he was an Ecclesiastical Commissioner; but I think he will perhaps be remembered especially in connection with two of those positions which appeal to the public—as Chancellor of the Exchequer (laughter) and as First Lord of the Admiralty. (Applause). The former post he held five years, and he was First Lord of the Admiralty twice—once in the early seventies and more recently the last five years of the past century. As Chancellor of the Exchequer, I think he appeals to all of us. We know Chancellors of the Exchequer are especially interested, as a rule, in certain articles of consumption, dear alike to both ladies and gentlemen, namely, tea, tobacco and alcohol (laughter), and in the present time I think we must all look back with a great deal of pleasure—or perhaps with regret—to those days when the Income Tax, instead of being 11d. or 1s. 3d. or 1s., was, shall we say, the modest 6d. But when we come to the other great position which Lord Goschen has held—that of First Lord of the Admiralty, then, I think, one may appeal to higher sentiments and nobler aspirations than those which are connected with the satisfaction of the appetite or the size of one's banker's balance. When we look back to the period one hundred years ago, when Nelson was eating his heart out with anxiety to catch the French, and when we think of four or five years ago when we were all consuming ourselves with apprehension lest our vessels might not reach Durban or Cape Town in sufficient time to enable the troops to get to Ladysmith, when we consider what is taking place, or has been recently, in Korean waters, in the last few months and weeks, we can appreciate of what great importance is it that the nation should have a navy that is efficient and equal to the calls which may be made upon it. Lord Goschen, I am sure, will be remembered as one who was instrumental in keeping the navy up to its fullest efficiency (applause), and we must all remember his period of office with that feeling. Lord Goshen has now left the f'castle of war vessels—if f'castle there be—he has left the halls or chambers of finance, and he now paces peacefully academic groves, and in that connection his presence here to-day is exceptionally interesting and gratifying. The University of London has done good work, and is doing good work, but the University of London is yet young, it has not the seniority or the prestige of some other Universities. I think it is exceptionally appropriate that we, the Medical School of Guy's Hospital, the University of London, should be reviewed and have its work approved, as has been done to day, by the Chancellor of the University of Oxford. (Applause).

Sir Thomas STEVENSON, our most recently created knight, and senior member of the Medical School, who was received with great cordiality, seconded the proposal and said:—Mr. Bonsor, ladies and gentlemen—I am not going to detain you long with any speech on the admirable

address of Lord Goschen. I have heard, during many years, a great number of addresses on occasions like this, but I cannot recall one to which I have listened with greater pleasure, and from which, as an old student of Guy's, I have derived more profit. I heartily commend to all our young men, and to the older men, his sympathetic words, the admirable tone that has characterised that address and which has warmed so many hearts; and I think I have seen not a few eyes bedimmed with his most eloquent and appropriate remarks. I beg to second the motion of a vote of thanks to Lord Goschen. (Loud applause.)

The CHAIRMAN: Ladies and gentlemen—We are all extremely grateful to Lord Goschen, and I think the best plan will be to carry the resolution by acclamation.

This was most heartily acceded.

Viscount GOSCHEN:—Ladies and gentlemen—The Dean was good enough to inform me when I accepted the office of addressing you to-day that I must speak for at least twenty minutes and not for more than half an hour. I fear I dangerously approached the latter limit, and so I will not detain you more than a moment. Only let me say this: that the speech of the mover of this resolution reminded me of the Navy; and that called to mind that while I have made claims in many departments for the entrance of competent doctors I have not put in a word for my old department the Admiralty. So let me say that if any students feel they would like a somewhat adventurous life, with a great deal of change, great attractions, excellent society, and the highest possible tone, let them come as medical men on board a man-of-war. I am grateful for what has been said with reference to my connection with Oxford. I could have dealt with the value of the connection, and especially the character of the relations that we have with the great London medical schools, but I felt this was not entirely the occasion to dwell upon those points. I prefer to-day to address the students; but as Chancellor of Oxford I may say the University is more and more taking the deepest interest in the Medical School and the questions connected with its relations to the great hospitals which have at all times latterly occupied its attention. I beg to thank you very heartily. (Loud applause.)

This terminated the official proceedings and a general exodus for the park ensued. There the band of H.M. 1st Life Guards rendered the following admirable programme to the pleasure of all present:—

March, "Viscount Nelson" (Ziehle); Overture, "Haydeè" (Auber); Selection, "The Earl and the Girl" (Caryll); Duet (Cornet and Euphonium), "Excelsior" (Balfe); Dance, "Smoky Mokes" (Evans); Cornet Solo, "O dry those tears" (Riego); Valse, "The Choristers" (Phelps); Selection, "The Orchid" (Caryll); Piccolo Solo, "Sylvia" (Thiere); Morceau, "Hiawatha" (Moret); Walzer, "Hydropaten" (Gung'l); March, "Diamond Jubilee" (Hume).

"God Save the King."

Great interest was taken by the visitors in the medical and surgical wards, and especially in the new operating theatres.

The Wills Library, Raphael Home, College, Laboratories, etc., also attracted attention, while a few of the more venturesome were bold enough to enter the Museums.

Lord Goschen himself inspected the School and Nurses' Home, where he wrote his name in their visitors' book before leaving the Hospital.

Obituary.

Mr. John Birkett.

Born, 1814. Died, July 6th, 1904.

We regret to announce the death of Mr. John Birkett, F.R.C.S., formerly President of the College of Surgeons, and a member of the Hospital Consulting Staff since 1878. Mr. Birkett's connection with Guy's began as far back as 1829, when he entered as a student in October of that year. He was a Demonstrator of Anatomy about the year 1847, and was appointed an Assistant Surgeon in 1849. The latter office was vacated by him in 1853, when he was selected by the Governors to fill the vacancy on the full Staff caused by the sudden death of Mr. Bransby Cooper. For the next twenty-two years Mr. Birkett took a very large share in the surgical work of the hospital, and became an authority on diseases of the breast. His active work here came to an end in 1875, when he attained the age of 60 years, and was shortly afterwards appointed Consulting Surgeon to the hospital. Mr. Birkett found other interests in life besides Surgery, he was to be met at the shows of the Royal Botanical Society, and was a Fellow of the Linnæan Society. There are not many left at Guy's who knew him, but those who do will remember him as one who concealed beneath a somewhat brusque manner a gentle and considerate heart. Many a Guy's man now in practice will readily admit how much he owes to the teaching of "honest John" in the far off days, and will sympathise most deeply with his sons and daughter in the loss they have just sustained.

Testimonial to Dr. Orloff Combe.

We should like to acknowledge the following subscriptions sent us towards the fund for Dr. Orloff Combe, the announcement of the opening of which was made in the GAZETTE of March 26th.

	£	s.	d.
"J. H. G."	1	1	0
"L. F."	1	1	0
Thorne, Dr. J. M.	1	1	0
Walker, W. A. E.	1	1	0
Willan, Dr. G. T.	1	1	0

In Lighter Vein.

"FORTY YEARS ON!"

"Plain speaking is coming more and more into fashion, and there is no lack of prophets who say that in a few years' time all men and women will express their real thoughts in words."—*London Daily Paper*, June, 1904.

SCENE—Any Medical Ward at, of course, *any* Hospital. TIME—1944.

DRAMATIS PERSONÆ—Any Physician, with the usual following of H.-P., Clinical, Ward Clerks, Sisters, etc.

Sister (as *Physician* enters ward). Really, doctor, I wish you would come a little earlier; we all want our tea now. Dawdling round this ward after you is the most tedious part of my duties. If you did any good by coming I shouldn't mind so much, and might say nothing about it, but—

Physician. A thousand apologies, Sister. The fact is that you are not quite so attractive as once you were, and I am essentially an æsthete. Touching the last part of your remark, I would suggest that a subject on which you have nothing to say has yet to be discovered. I avoid your presence as I would avoid a parrot house; and were it not for the fact that I wish to teach these gentlemen and, incidentally, to prescribe for my patients——

A Ward Clerk. Your remark about wishing to teach us is absolute rubbish, sir. Everybody knows that it is the sound of your own voice which you love.

The H.-P. And as for prescribing for your patients—that is all rot! *I* do that, and there is nobody in this hospital better qualified to do it.

Physician. Honestly, gentlemen, I have always regarded the present generation as a set of egregious young asses; their conceit is only equalled by their ignorance. How is this case, Mr. B.? Is it the one in which I reserved my diagnosis?

H.-P. Yes, sir. In other words, it is the one that beat you, only you lacked the moral courage to confess your incompetence.

Physician (to *Patient*). Well, what is the matter with you?

Patient (the usual pessimistic variety). That is what I came here to find out.

(*Physician* inspects, palpates, percusses, auscultates, and fusses about generally. The "Firm" assume reposeful attitudes on the edge of the bed and upon adjacent chairs.)

Physician. Absence of cardiac dulness denotes a dilated condition of the lung. I also hear a loud systolic bruit; what does that show, Mr. A——?

Junior Ward Clerk. It shows that you have a very vivid imagination, sir. I speak with all humility, but nobody up here has so accurate an ear as myself, and I can hear nothing but the normal heart sounds.

Physician (dryly). I am sure the normal heart sounds must be infinitely obliged for your condescension, sir.

Patient (fretfully). I wish you gentlemen would say a little less and think about me a little more.

Sister (soothingly). The doctor must have his little joke, you know.

H.-P. The only drawback being that it is generally such a very silly little joke. Now, my jokes—

Clinical. Would be almost funny were it not for the fact that mine are infinitely better. When I call myself a humorist, I flatter myself—

Ward Clerks (wilfully misunderstanding him). You do!

Physician. I am unable to comprehend the purport of this report, sir.

A Ward Clerk. Which means——?

Physician (testily). That I can't read it! Why do you write so badly?

Ward Clerk (hurt). If my writing is good enough for me, surely it is good enough for you.

Sister. Anything is good enough for you, Mr. A——

Ward Clerk. And most things are too good for you, Sister, dear.

Physician. Really, gentlemen, your behaviour is hardly courteous!

H.-P. If you were a trifle less courteous and a litte more generous, you would be a more popular man, sir.

Sister. It is my birthday to-morrow, doctor.

H.-P. I will give you a penny for every year of your age, Sister. How much shall I owe you!

The Firm (unanimously). Oh! about five shillings.

Sister. I decline to correct such an obviously inaccurate statement.

Physician. Ah, well, good-day, Sister. Next time I come I shall expect to find you more amiable.

Sister. Good-day and good riddance, Doctor.

(Exeunt omnes.)

"THE WANDERING JEW."

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Proposed Memorial in the Chapel.

DEAR SIR,—There is at present no memorial of those students or members of the Nursing Staff who die while serving the hospital.

A desire has been more than once expressed, lately, that some such memorial should be placed in the Chapel, and it has been suggested that it should take the form of a Roll of Names, with the date of death.

The Chapel Committee has had the suggestion under consideration, and with the consent of the Court of Governors, has commissioned Messrs. Powell & Son, of Whitefriars (with the help of Mr. Woodd, the Hospital's Surveyor), to make a scheme.

They have sent us a sketch in which each of the eight arched recesses under the galleries is to be filled with a figure in *opus sectile* mosaic work, and the spaces between are to be panelled with oak.

These oak panels will bear upon them, either carved or affixed, the names in the proposed memorial, and any tablets which the Governors may hereafter erect. The Chapel might, if carefully treated, be made a very beautiful one, and the names of Messrs. Powell & Son is sufficient guarantee that the work will be good.

It is probably beyond our reach to attempt the whole scheme at present, but we are anxious to give the order for as large a part of it as possible, at one time, to save expense and delay.

Subscriptions for the purpose will be gladly received either by Mr. C. H. Wells, the Treasurer's Secretary (who kindly acts as Treasurer of the Chapel Funds), or by myself.—I am, yours faithfully,

HENRY LE FANU,
(For the Chapel Committee).

Guy's Hospital, London, S.E.,
July 11th, 1904.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. F. Rogerson (Dr. Taylor); R. W. Allen (Dr. Hale White); W. N. May (Dr. Pitt); C. M. Stevenson (Sir Cooper Perry).

Clinical Assistant in the Surgical Wards.—Mr. A. M. Benett (Mr. Symonds).

Ophthalmic Dressers.—Messrs. R. Felton (Mr. Higgens, August 1st); P. P. Cole (Mr. Brailey, August 1st); F. W. Morton Palmer (Mr. Higgens, September 16th).

Surgeons' Dressers.—Messrs W. P. Purdom, R. J. Bentley, H. G. Gibson, I. R. Cook, T. R. Harvey, P. C. Litchfield (Mr. Lucas); E. E. Rendle, R. S. Harper, M. Leckie, G. H. Morris, F. A. Sharpe, R. M. Wingent (Mr. Golding-Bird); E. Bellingham Smith, G. W. Nicholson, H. A. Watney, C. F. Fothergill, A. G. Jones, A. S. Morton Palmer (Mr. Jacobson); E. H. Adams, B. B. Metcalfe, W. Welchman, J. H. Mayston, L. H. Burner, W. H. S. Burney (Mr. Symonds).

Obstetric Dressers.—Messrs. V. A. P. Costobadie, R. P. Lewis, C. M. Wenyon, A. H. Miller (September-October).

Externs.—V. A. P. Costobadie, H. C. Cameron, R. A. Chisolm, F. D. Crew, G. H. K. MacAlister (August); J. A. C. Greene, C. W. R. Preston, H. S. Knight, W. Reeve, F. T. H. Wood, A. H. Miller (September); G. Hamilton, G. F. Greening, T. Norman, S. Reader, A. Walker (October).

Civil.

CAMPKIN, HUGH T., L.D.S. Eng., has been appointed Honorary Dental Surgeon to the St. Pancras and Northern Dispensary, Euston Road.

LOCKYER, G. E., M.R.C.S., L.R.C.P. Lond., has been appointed District and Workhouse Medical Officer of the Amesbury Union.

Naval and Military.

Staff Surgeon L. BIDWELL, R.N., has been appointed to the *Medea* and Staff Surgeon J. C. G. REED to the *Vulcan*.

Lieutenant E. B. DOWSETT, the Woolwich Companies, Royal Army Medical Corps (Volunteers), is promoted to be Captain.

Presentation.

Mr. WALTER C. C. PAKES, M.R.C.S. Eng., L.R.C.P. Lond., who has resigned the post of Medical Officer of Health to the Rand Plague Committee, has been presented with a silver spirit service and a gold chronometer, the latter bearing the following inscription: "Presented to Dr. Walter C. C. Pakes on his resignation as Medical Officer of Health, Rand Plague Committee, by the members of the Staff, as a mark of their appreciation and esteem. May 31st, 1904." In connection with the presentation a smoking concert was held.—*British Medical Journal.*

Reviews.

The price of books submitted for review should in every case be stated.

Devices and Desires. By P. H. Lulham, M.R.C.S., L.R.C.P. pp. 211. (Brimley Johnson). 1904.

To declare oneself a minor poet needs courage in these days, even among the most recondite, and to wed the muse after a life beneath the public gaze, such as that which had been previously led by Mr. Lulham, argues great toughness of moral fibre. For I, *moi qui vous parle*, knew the poet in his salad days, when as a well-groomed drawing-room *farceur*, the only white artist among a crowd of black, he delighted suburban audiences in company with the famous or infamous Disguysed Minstrels. His renunciation of such scenes and his attempts to rise on the stepping-stones of his dead self to higher things, are at the present moment engaging our attention and critical faculty.

Leaving Mr. Lulham's past alone, we can say at the outset that his poems have given us great pleasure, and abundant proof that he has the soul of a poet in him.

His technique is not always at the same high level, and occasionally the phrasing very nearly drops from the sublime to the bathetic, but there are many poems in this small volume which have more than justified Mr. Lulham in appealing to the judgment of the public.

To quote from "The Doctor," perhaps, next to the poem to his Mother, the best in the book, the following lines ring very true and human:—

"Well, here's the room where I've sold the best of my brains for twenty years,
And listened, often sick to the soul myself to others' hopes and fears;
'Twas a leading of the blind by one but a little less blind I know,
I sell others advice, forsooth, who have tangled my own life so!
Still, mine it has been a many times to bid back hope to the breast,
Or brace a heart to bear the truth when put to the bitter test."

In the metre and arrangement many of the poems remind one of W. E. Henley's "Rhymes and Rhythms," and little known though Henley is, appreciative and unconscious imitation of him shows a right judgment of minor poetry in Mr. Lulham.

"Devices and Desires" is a most creditable achievement, and we hope Mr. Lulham will in the future give us the pleasure of reading as pleasant a volume of songs. Meanwhile, we can only recommend it to all readers of the GAZETTE, to many for the interest of remembering an old and well-known friend, to others who do not know the poet, for the sake of the poetry alone.

What we owe to Experiments on Animals. By Stephen Paget. (Scientific Press Ld.) pp. 72. 1s. 6d. net.

This is a review, in a very sketchy form, of the result of experiments on animals. It shows our addition to medical knowledge, and the amelioration and advance in treatment as a consequence. It is, of course, a justification, supported by undeniable facts, of vivisection.

General Pathology of Inflammation, Infection and Fever. By E. W. Ainley Walker. (H. K. Lewis.) pp. 272. Price 4s. 6d. net.

These are a series of Gordon lectures, delivered at this hospital, and now appearing in book form. They are full, clear, and scientific from beginning to end. Dr. Walker has a good style, and as a consequence the whole is very pleasant reading.

Ophthalmological Anatomy. By J. Herbert Fisher. (Hodder and Stoughton.) pp. 188. 7s. 6d.

A well-printed book, on light paper, easy to hold and handle though of large size page. It is pleasantly written in an eminently readable manner—anatomy was never better written. 106 pages are filled up with the anatomy of the ophthalmic system, for, though the author does not enter into histological details, he gives us the latest work on the paths of visual sensation as observed in the brain. Many points difficult to understand in the ordinary text books are here very well explained, as, for instance, Tenon's Capsule and its relation to the Conjunctivæ.

There is an excellent description of the action of the external eye muscles, in which the author shews us that the term "rotation" is usually used in a wrong sense, and points out that the opinion commonly held that lateralization of the eye-ball is carried out by the external and internal recti unaided is erroneous, as several muscles are always used for those movements.

Very good rules are given for the estimation of squints, and we are told that the correct treatment for anterior venous aneurysm of the cavernous sinus is by ligature of the internal and not the common carotid, as hitherto practised, as otherwise the result is spoilt by the circular current of blood which flows down the internal carotid and up the external of the same side. The author also considers that the true way of attacking cavernous sinus thrombosis is per the orbit, the eye having been previously excised, as he considers that drainage is better established so than through the nose. The book ends with a series of illustrative cases, among which is one of orbital cellulitis, which we are assured is not very common, and is nearly always caused by orbital periostitis, hardly ever by spread of infection from the ethmoidal air cells, an important fact considering the frequent occurrence of ethmoidal disease.

A Manual of Surgical Diagnosis. James Berry. pp. 363. (Messrs. J. & A. Churchill). 6s. net.

This book, the result of twenty years' clinical experience, principally at St. Bartholomew's Hospital, fulfils admirably the function of such books, which we take to be to fill in the various details of the text books—to dot the *-i's* and cross the *-t's*. It does not wander too far into the realm of exact description, nor does it degenerate into a series of lists, each headed by a

symptom, and containing the possible causes thereof; for diseases cannot be identified clinically by means of a museum catalogue.

We note with pleasure that Mr. Berry utters a protest against examining unnecessarily, even for the purposes of clinical teaching, patients who are *in extremis*, or nearly so. He also lays great stress on the necessity of estimating probability as an aid to diagnosis. When in doubt diagnose the commonest, though we notice that in discussing the various ulcers of the tongue he does not mention their relative frequency. Again, is the author quite correct in describing chronic superficial glossitis as a superficial *ulceration?*

The author considers that exploratory operations for mere diagnosis are never justifiable, and that exploratory tapping with a needle should rarely be resorted to.

We should like to have seen more hints given as to differential diagnosis in the various chapters, especially between lateral sinus thrombosis and cerebral abscess, as complications of middle ear disease, and between intestinal obstruction and peritonitis. A chapter is given to each of the latter, and yet no mention is made of the pulse in either, though after-indications for operations in an abdominal case are far more important than an exact estimation of the seat of obstruction.

There are two good chapters on diseases of the spine and joints, but in the latter only slight reference is made to the frequent difficulty experienced in diagnosing intra-articular from extra-articular ear swellings—especially enlarged bursæ.

Mr. Berry, we notice, prefers to palpate kidneys sitting in front of the patient, who also is in the sitting position, and draws attention to the clinical fact that a fast pulse is not uncommonly found in cases of simple goitre.

Sport.

LAWN TENNIS FIXTURES.

Saturday, July 16th.

G.H.L.T.C., I., v. Kent, away.

Saturday, July 23rd.

" I., v. Gravesend, away.

" II., v. East Sheen "A," home.

Saturday, July 30th.

" I., v. Boundaries, away.

POLO FIXTURES.

Tuesday, July 19th.

G.H.S.C., v. Southwark, away.

Cricket.

GUY'S v. GRAVESEND.

This match was played at Gravesend on Saturday, July 2nd. Rain robbed the home side of victory. Bookless and Tolhurst played good innings for us. Scores:—

GUY'S.

R. Willan, c sub, b McAulis	4
J. S. Bookless, lbw, b Casteley	50
A. M. Tolhurst, c & b Veal	42
F. Husbands, c Veal, b Casteley	0
H. Simms, c Veal, b Casteley	20
H. D. Wyatt, c Robson, b McAulis	9
E. Whelon, c Tabrum, b Casteley	0
S. C. Bowle, c Casteley, b McAulis	8
S. M. Wells, b Casteley	0
T. R. Harvey, not out	3
S. A. Piper, c Robson, b McAulis	1
Extras	9
Total	146

GRAVESEND.

C. S. Veal, c Bookless, b Piper	4
L. H. W. Troughton, c Wyatt, b Bowle	32
L. G. P. Casteley, c Wyatt, b Bowle	61
C. J. Robson, not out	22
F. W. Boorman, b Bowle	5
F. H. Stevens, not out	0
Extras	13
Total (4 wickets)	137

GUY'S v. M.C.C.

This match was played at Honor Oak Park, on Wednesday, July 5th. The visitors brought a strong side, which we succeeded in getting rid of for 219, Wyatt and Davies bowling well. We only made 181. Our first 5 wickets fell for 15, or we should have probably won. Wells kept wicket very well for us. Simms, Archer and Bookless batted well.

M.C.C.

A. E. Earnshaw, c Wells, b Wyatt	1
C. E. Round, b Davies	37
R. E. More, c Willan, b Wyatt	50
R. W. Nicholls, c Barber, b Willan	78
—. Newstead, b Wyatt	0
F. Nightingale, b Davies	0
C. N. Moore, c & b Davies	13
—. Bean, b Davies	10
—. Ives, not out	7
—. Russell (T.), lbw, b Davies	6
—. Allsopp, b Davies	11
Extras	6
Total	219

GUY'S.

H. Barber, b Newstead	3
H. D. Wyatt, b Allsop	0
R. Willan, c Moore, b Allsop	2
H. M. Newman, c Russell, b Newstead	0
F. Husbands, run out	4
J. Bookless, b Allsop	41
H. Archer, c Nightingale, b Newstead	41
H. Simms, c Nicholls, b Allsop	56
E. Whelon, not out	10
S. M. Wells, b Allsop	0
L. G. Davies, c Russell, b Newstead	7
Extras	17
Total	181

GUY'S 2ND v. LONDON 2ND.

SEMI-FINAL JUNIOR CUP TIE.

This match was played on Monday, July 11th, at Chiswick. We batted first, and declared with the score at 251 for 8 wickets. Norton batted well for his 70. London started their innings soon after five o'clock, but were all out in 1 hr. 15 mins. Leeming and Bartlett were responsible for this; they were well backed up in the fielding, several good catches were made.

GUY'S 2ND.

E. L. Norton, c Rigby, b Grogono	70
A. Leeming, c Watson, b Daly	32
H. H. Carter, c Daly, b Rigby	30
A. Tubby, c Watson, b Grogono	18
E. Whelon, c and b Barnes	23
G. F. Allison, st Watson, b Grogono	6
H. H. Moyle, c Rigby, b Grogono	8
G. F. Greening, st Watson, b Grogono	15
O. G. Iliffe, not out	22
G. N. Bartlett, not out	15
Extras	12
Total (8 wickets)	251

D. Reynolds did not bat.

LONDON 2ND.

A. H. Pollard, c Iliffe, b Bartlett	5
S. R. Harrison, c Iliffe, b Bartlett	3
H. A. Barnes, b Leeming	1
J. Grogono, c Bartlett, b Leeming	11
H. Gibson, b Bartlett	0
W. G. Gayton, c Tubby, b Bartlett	15
A. S. Daly, c and b Leeming	6
D. G. Evans, c Norton, b Bartlett	2
C. M. Rigby, c Greening, b Leeming	2
J. Owen, not out	3
G. H. Watson, b Bartlett	1
Extras	6
Total	55

GUY'S 2ND XI. v. BLACKHEATH "A."

Played at Blackheath. We batted first and made 171. Our opponents made 259 for 5 wickets in 100 minutes. They went for the bowling from the start, and soon demoralized our fielding. To quote the *Daily Mail*, there was an epidemic but it was'nt catching.

GUY'S 2ND.

S. C. Bowle, c Cooper, b Robertson	23
G. N. Bartlett, b Robertson	20
H. H. Carter, s Lewis, b Davies	22
E. L. Norton, not out	48
H. H. Moyle, b Davies	12
T. R. Harvey, b Davies	0
R. S. Bennet, b Davies	0
O. G. Iliffe, c Cooper, b Robinson	7
B. T. Verver, s Lewis, b Davies	4
G. Russell, b Robertson	6
F. Crouch, b Davies	15
Extras	14
Total	171

BLACKHEATH (A).

H. G. Symons, b Bartlett	89
M. S. Poore, b Bowle	0
Capt. C. E. Wilson, c Russell, b Bowle	70
A. C. Grant, c Bowle, b Bartlett	3
W. A. Lewis, not out	33
C. J. Robertson, l.b.w., b Verver	21
S. Knowles, not out	24
Extras	19
Total (5 wkts.)	259

A. W. Lewis, S. W. Payne, Capt. Davies, L. K. Cooper, did not bat.

GUY'S 2ND v. R.I.E.C. "A."

This match was played on our ground, but bad weather brought about an unfortunate ending. Norton played a good innings for us.

GUY'S 2ND.

A. Leeming, c Perry, b Madapa	16
G. F. Allison, b Madapa	15
G. Greening, c Blanford, b Madapa	20
E. L. Norton, b Perry	50
R. S. Bennett, c Connor, b Perry	8
A. R. Wilson, c Blanford, b Perry	13
D. Reynolds, b Perry	8
B. T. Verver, b Madapa	10
O. G. Iliffe, not out	3
Extras	17
Total (8 wickets)	160

S. Mutch and V. Townrow did not bat.

R.I.E.C. "A."

J. D. Way, not out	11
A. D. Madapa, run out	4
P. W. Hill, not out	3
Extras	2
Total (1 wicket)	20

Northby, E. V. Ellis, O. P. Connor, H. R. Blanford, C. O. Lowsley, R. S. Bourke, P. S. Perry and A. G. Ronald did not bat.

GUY'S 3RD XI. v. HOS.-SCHO.

Played at Honor Oak Park, May 28th, 1904, Guy's winning by 6 wickets. Hos.-Scho. winning the toss batted first on a plum wicket, scoring 97 all out. Harvey played a great game for 47 not out, and Verver bowled well. Scores:—

HOS.-SCHO.

Arnold, c Simms, b Verver	2
de Sault, b Verver	14
Wood, b Verver	4
King, b Moyle	8
Russell, b Bartlett	9
Copsey, b Bartlett	17
Pullen, not out	0
Holbrook, c & b Verver	4
Benett, b Townrow	19
Bennett, b Verver	13
Cheeseman, c Bastard, b Verver	0
Extras	7
Total	97

GUY'S.

G. N. Bartlett, b Russell	20
H. Simms, b Arnold	2
T. R. Harvey, not out	47
H. Moyle, c King, b Copsey	14

P. C. Litchfield, b Russell	22
A. Vernon-Taylor, not out	14
Extras	12
Total	131

J. Johnston, H. R. Bastard, B. T. Verver, V. Townrow and T. Edey did not bat.

GUY'S 3RD XI. v. NEW ELTHAM.

Played at New Eltham, June 11th, 1904, Guy's winning by 20 runs. Scores:—

GUY'S.

—. Elliott, b Wilson	4
—. Atkinson, lbw, b Wilson	8
D. Reynolds, c Jones, b Beale	50
A. M. Bennett, c Murphy, b Warren	12
C. Morris, b Martin	0
J. Smalley, b Beale	3
H. R. Bastard, b Beale	0
M. M. Munden, lbw, b Wallis	4
W. E. Fox, b Beale	0
L. Reynolds, not out	2
H. N. Eccles, c Martin, b Wallis	13
Extras	14
Total	110

NEW ELTHAM.

Jones, run out	22
Warren, c Munden, b Morris	20
Wallis, c Eccles, b Morris	10
Richmond, c Elliott, b Morris	0
Martin, c Eccles, b Munden	4
Wilson, run out	5
Roosel, run out	10
Beale, b Munden	3
Murphy, c Elliott, b Munden	9
Huggerty, run out	0
Woolgar, not out	0
Extras	7
Total	90

Guy's Hospital Lawn Tennis Club.

On Saturday, June 25th, we drew 4–4 with Brixton Wanderers, one event being unplayed, as one of our team had to leave.

A. Zorab and R. H. J. Swan lost to S. Constanduros and E. J. Andrews, 4–6, 2–6; beat J. W. U. Jones, 6–3, 8–6 H. C. Winckworth and C. W. Greene lost to S. Constanduros and E. J. Andrews, 6–1, 3–6, 4–6; lost to F. Palmer and P. Ash, 6–3, 4–6, 5–7; beat J. W. and L. Jones, 6–2, 7–5. A. S. M. Palmer and F. Morres lost to S. Constanduros and E. J. Andrews, 2–6, 2–6; beat F. Palmer and P. Ash, 6–3, 6–4; beat J. W. and L. Jones, 6–4, 7–5.

Our appearance in the Inter-Hospital Cup Tie proved a miserable fiasco; we played against London and lost the singles by six matches to love, and the doubles by seven matches to love.

On Saturday, July 9th, we won our first match of the season against Harold, whom we beat by five events to four.

F. W. M. Palmer and H. C. Winckworth lost to R. B. and C. Ransford, 8–10, 1–6; beat W. A. Bright and B. Clogg, 6–1, 6–2; beat H. Eccles and H. Green, 6–8, 6–2, 11–9. L. J. J. Orpen and C. W. Greene lost to R. B. and C. Ransford, 0–6, 6–1, 4–6; beat W. A. Bright and B. Clogg, 6–3, 6–3; beat H. A. Eccles and H. W. Green, 2–6, 6–4, 6–3. Barker and Davies-Colley lost to R. B. and C. Ransford, 2–6, 3–6; beat W. A. Bright and B. Clogg, 7–5, 6–8; lost to H. A. Eccles and H. W. Green, 2–6, 4–6.

Change of Address.

Dr. John Bowes, from 7, Marine Terrace, to East Hill House, East Street, Herne Bay.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Calendar.

July, 1904.
Sat. 16.—School Exam. in Histology.
Mon. 18.—Exam. for the Beaney Prize for Pathology begins.
Tues. 19.—Exam. in Histology for Junior Prizes for General Proficiency.
Thur. 21.—Messrs. Lucas and Lane's take-in; Drs., T. Thomas and H. F. White; Cl., W. M. Mollison.
Fri. 22.—Exam. in Dental Histology.
Exam. in Operative Dental Surgery.
Sat. 23.—Exam. in Elementary Anatomy for Junior Prizes for General Proficiency.
School Exam. in Elementary Anatomy.
Lectures cease.
Mon. 25.—Summer Session ends.
Tues. 26.—Pre. Sci. (L.D.S.) Exam.
First Conjoint Exam. begins.
Thur. 28.—Messrs. Golding-Bird and Dunn's take-in; Drs., B. B. Metcalf and E. E. Rundle; Cl., O. V. Payne.
Test Exams. for Revision Classes for Final L.D.S. Eng., begins.

Births.

AUSTIN ROBINSON.—On June 2nd, 1904, at the Sanatorium, Nottingham Road, Natal, the wife of Dr. F. Austin Robinson, D.M.O., Nottingham Road (née Lilian Rogers Jenkins), of a son.

WAY.—On July 9th, at Kenilworth Lodge, Southsea, the wife of Montague Way, M.R.C.S. Eng., L.R.C.P. Lond., of a son.

Death.

BIRKETT.—On July 6th, at 1, Sussex Gardens, Hyde Park, W., John Birkett, F.R.C.S., in his 90th year.

R. E.—ED.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 424.] JULY 30, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	309–311
Specialities	311
Acute Intussusception. Clinical lecture by Mr. F. J. Steward	311–316
Correspondence	316–317
Notice	317
In Lighter Vein	317–319
Revised Syllabus for L.D.S. Examination	319–320
Change of Address	320
Evolution in its Relation to Comparative Odontology	321–330
Reviews	331
From the Gazette's Special Pathologist ...	331
Nursing News	331
Students' Chapel Choir	331
Sport	332
Pass List	332
Appointments	332

Passim.

THE New Front Surgery is at last open, and we hear that two Americans have already requested to be shown over, having been sent over from the States to acquire ideas for a new hospital about to be built in Chicago. Sister Surgery is indeed to be congratulated, as every penny that has been spent there has been raised by her own efforts and appeals in the newspapers. To the dresser who only worked in the old Surgery the new "Department" is indeed a revelation, and is, perhaps, bewildering; it is often difficult to find a patient dumped down in some out-of-the-way corner, while the multiplicity of rooms is suggestive of an Eastern palace. The beautifully fitted up dispensary will prove the happy hunting ground of many a dresser who enjoys the novelty of making up his own prescriptions, while the patient crowd is kept waiting.

IT seems strange and an unnecessary piece of cruelty that, though the Dressers' Room has been in its present quarters now for some months, it has not yet been connected with the Surgery by bell or speaking-tube, so that the presence of a patient has to be announced by the nurse in person. The frequent climbing of stairs is tiring, and could be easily obviated at the cost of a few shillings, an expense which would surely be justified in view of the amount that has been spent on the new rooms. Where are the photographs of groups which adorned the walls of the old room? Though frequently broken, they were a never-ending source of interest and amusement, for we were able to view the youthful features of men now popular members of the Staff.

SISTER ESTHER has left us to take up her post as Matron of the Royal Surrey County Hospital, whither she has been accompanied by several recent Guy's nurses as Sisters. While congratulating her on her appointment, we regret her departure from the Hospital, where she had made many friends, who presented her on leaving with a handsomely-fitted dressing-bag. As Sister Mary, she came in touch with every medical ward clerk, and will be especially remembered for her kindness in giving demonstration to the clerks on many points of nursing technique which it is necessary they should know.

WE heartily congratulate the Cricket Club on having won both the Senior and Junior Inter-hospital Cups. In the Senior Cup, our First XI. met and successively vanquished Charing Cross, Westminster and St. Mary's; they then

met London in the final and beat them by nine wickets. Our score of 448 was largely helped by scores of 148 from Morres and 116 from Wyatt; to this they responded with 216 and 292, leaving us 61 to get to win, which we did for the loss of one wicket—a capital achievement for which the team is to be greatly praised. The second team met London in the semi-final and beat St. Thomas's easily in the final—Whelon making 102 out of a total of 293.

We are pleased to be able to announce the foundation of a Guy's Hospital Fire Brigade—G.H.F.B., as the men wear on their caps. To trace the rise of this corps one is compelled to go far back into ancient history. All will remember a notice, which held a prominent position outside the door of Naaman Ward, giving instructions that, in case of fire, information was to be conveyed to Dr. Steele and the Plumber. This self-constituted Fire Brigade, small, though doubtless with powers to add to their number in cases of emergency, held undisputed power for many years, till Dr. Steele died and left the Plumber alone in his glory. Recent alterations outside the old Theatre have required the removal of the notice above mentioned, and accordingly the authorities have increased the size of the Brigade from one to five—a clear gain to the community, though we regret to see that Dr. Steele's successor has not enrolled himself in the ranks. The Plumber, however, still retains his position.

These amateur firemen are dressed in close imitation of their professional brethren with the usual complement of axes and spanners hung in various places about their bodies, and might have been seen drilling one afternoon last week. They were drawn up in front of Clinical, and, having been inspected and re-arranged, commanded to extinguish a fire in the neighbourhood of the Bakery. It was an awe-inspiring sight to see these men rush up the Colonnade, dropping into a sheepish walk when they caught a friend's eye, and bring out the hose-cart at the double, which they took down the Colonnade steps reckless of consequences. A report has since been sent in—"Called to an imaginary fire near Clinical, outbreak subdued in six minutes; damage done, one fireman's finger crushed, a quantity of paint removed from hose-cart, much water wasted."

Would it not be possible to form a fire brigade in the College, as then a large number of men would be available at any hour of the night, the workmen, on the other hand, living in most cases some distance from the Hospital? The men need not wear uniform, but could be drilled and taught the positions of the various hydrants, so that as little delay as possible should occur in coping with an outbreak at night. Many will remember a chimney fire in the Surgical wards twelve months ago, which took one or two hours to extinguish.

We print in another column a letter from a Guy's man, who evidently enjoys the Englishman's privilege of nursing a grievance, though we fail to see exactly why he complains, when the remedy lies partly in his own hands. He meets nobody he knows at the Biennial, and accordingly stays away, as do several of his friends. Why does not "Hakim" come himself and persuade the men he mentions to come too, for then there would be the nucleus of a table, and a group of men knowing one another, a group which would grow as quickly as does a snowball. The plan he suggests of quinquennial secretaries would, we think, be hard to arrange, but need not be abandoned for want of completeness, as keen secretaries could be found for a few periods of five years.

We have much pleasure in announcing that the Students' Club have accepted the plans for a grand stand, which they intend shortly to erect at Honor Oak, and they hope will be ready for use at the beginning of October. The Gazette Committee have kindly advanced the necessary funds, and the stand, which will be a reproduction in miniature of the grand stand at Richmond, should be capable of seating about 160 people. Though members of the Students' Club and ladies will, as before, have free access to the ground, they will be required to pay the same admission fee to the stand as

other visitors, which we will probably be fixed at sixpence. The certainty of a covered seat in wet weather will, it is hoped, draw a much larger gate to the various matches.

THE old squash court is now in the hands of the "wreckers" and the Residents, anxious to avoid the tendency towards adiposity provoked by good living and no exercise, must possess their souls in patience until the new court is built on a site at the rear of the swimming bath. Surely it would have been possible to build a new court before the old one was demolished! Dare we hope for a covered court so that play may be possible in wet weather? At all events we hope that the architect will consult with some of the prominent squash players before drawing up his plans.

THE dog days are upon us, and accordingly we find it necessary to appeal for copy. Hot weather does not facilitate the scratching of the editorial pen, and yet copy is necessary, though contributors are few. Some, when they write, exasperate by insisting on their anonymity. It is an unbroken rule of the GAZETTE that nothing can be published unless the Editor knows who is the writer thereof. This alone has prevented the use of a manuscript received in the colonnade box this week and signed "The Unknown." Will this contributor kindly send his card to the Editor, who will, of course, respect his anonymity?

Specialities.

CHLORYL ANÆSTHETIC.

We have received from Messrs. Duncan, Flockhart & Co. a sample of this preparation which consists of absolute ethyl chloride. The anæsthetic is supplied in cylinders of convenient size and shape containing 60 cc. and provided with a spring stop-cock, by means of which the required dose of the anæsthetic can be introduced into the inhaler in about two seconds. Ten successive administrations for dental operations gave an average anæsthesia of eighty seconds with an average dose of 3·5 cc. In all cases anæsthesia was quickly induced, no unpleasant after effects were noticed, and the anæsthetic, which has no unpleasant odour, was quietly and easily inhaled. We can strongly recommend the use of this preparation of ethyl chloride for dental and minor surgical operations.

Acute Intussusception.

CLINICAL LECTURE BY MR. F. J. STEWARD, July 8th, 1904.

GENTLEMEN,—I thought I would first of all go over one or two general points about intussusception, and then deal more particularly with its clinical aspects.

There are many varieties of intussusception, but I shall not bother you with a list of these, but will content myself with saying that an intussusception may commence in any part of the small or large intestine, and that the common forms are those which arise in the neighbourhood of the ileo-cæcal valve, either just above it in the end of the ileum, or just below it in the cæcum.

Let us now consider for a moment what happens as the result of the production of an intussusception. In early stages the lumen of the bowel may be patent, but very soon obstruction and then strangulation are brought about. The cause of this becomes apparent on considering the portion of mesentery that is drawn in with the intussusception. The tightness at the neck soon begins to cause some obstruction to the venous return with the result that the intussusception and the included mesentery become engorged. They also become swollen, partly owing to this venous engorgement, and partly owing to serous exudation into the tissues. These changes produce four important results:—

1. Increased secretion by the mucous glands, and hæmorrhage from the giving way of small engorged vessels, cause a collection of blood and mucus within the bowel. The discharge of this *per anum* constitutes one of the most important symptoms of intussusception.

2. Obstruction to the lumen of the gut is caused by the swelling, and so another symptom is accounted for.

3. The swelling of the intussusception causes it to fit the sheath tighter and tighter, until it eventually becomes *irreducible*.

4. The engorgement reacts on the mesentery itself, and increases the pressure on it at the neck of the intussusception. In consequence the arterial supply is interfered with, so that the blood supply to the intussusceptum is entirely cut off, and strangulation results.

Further, the engorged or strangled intussusception quickly becomes infected by the organisms present in the intestine, gangrene being thus hastened and septic absorption set up.

A certain amount of peritonitis is also soon set up, glueing the layers of the intussusception

together and also causing *all* the layers at the neck to adhere together. This is important, because it allows a natural cure to become possible, for should the patient live long enough the whole of the gangrenous intussusceptum may become separated at the neck and be passed *per anum*.

The *causation* of intussusception is not by any means clear, although occasionally a definite cause can be assigned. In some cases a tumour, usually a polypus, projecting into the bowel acts as the cause, probably by exciting peristalsis in the neighbouring portion of the bowel, and so becoming gripped and drawn in. It is known also that irregular contractions will produce invagination, for sometimes at the moment of death, or just after, when irregular peristalsis does occur, several intussusceptions are produced. During life irregular contractions may be caused by enteritis, the irritation set up by some indigestible food, or even by a change of food. Bearing this out there is occasionally the history of diarrhœa, or of a change of diet immediately preceding the onset of the intussusception.

Turning now to the *clinical* aspect of the condition, I shall illustrate the main points by reference to a table I have prepared of the last fifteen cases that I have operated upon.

Taking these cases the average age was fourteen and a half months, but in such a small collection that age is abnormal. For instance, the third case is that of a boy six years old, and the tenth was four years old. I think these two cases should be taken out of the list. Then the average age is six and a half months, and that is about the common age. As to sex, there is not much to notice of importance, in my list the males number eight and the females seven.

As to the type of children affected, they are nearly always fat, healthy, and well nourished. That fact may have some bearing on the production of the intussusception, because naturally their peristalsis would be vigorous. Another peculiar fact, which I cannot help mentioning to you, is that the majority of them are the only children. That may have something to do with improper feeding owing to inexperience, though it does not fit in with the fact that these children are generally healthy.

Now as to symptoms.

1. *Vomiting* is nearly always present in cases of intussusception, and in many cases it is the first symptom noticed. Occasionally, however, it is absent, and in my fifteen cases it was absent from two, once in a baby aged six months and again in one aged seven months. The vomiting is usually persistent and occurs quite apart from taking food, so that it is clearly due to the obstruction in the bowel, which sets up regurgitation from the intestine into the stomach.

2. With regard to the *passage of blood and mucus*, you will see it is mentioned in all but one of these fifteen cases, that one being a boy aged six years. So the passage of blood and mucus per rectum is a very constant sign of intussusception, so much so that it would be unwise to diagnose intussusception in its absence. It is, as I have told you, the result of the early congestion which takes place. Sometimes there is a good deal of mucus and not much blood, sometimes a good deal of blood and only a little mucus. The last case I had was that of a child who was in Clinical a month ago, and was very striking in that respect. It was taken into the ward on account of hæmorrhage from the bowel, and there was a quantity of bright blood passed every few minutes.

3. The next most important symptom is the presence of a *tumour*. In my fifteen cases tumour was absent only once, and that was in the boy aged six, who was rather an abnormal case. The tumour in these cases is usually situated along some part of the course of the colon, and it is correctly described as a sausage-shaped tumour, the curvature being towards the umbilicus. You would expect to find it there because the majority of intussusceptions start in the neighbourhood of the cæcum, and as the mesentery or meso-colon is attached more to the inner than to the outer side, clearly the pull is towards the inner side, resulting in that curve towards the umbilicus.

It is not always easy to feel this tumour, but it is extremely important to ascertain whether one is present or not because practically the diagnosis is dependent on the detection of a tumour, as I shall tell you later. Therefore, in every case of doubt you should give an anæsthetic, so that a tumour if present will be easily felt. Of course a tumour in an infant's abdomen should be easy to feel, but sometimes they are very ill, and the moment you begin to examine them they cry, and the abdominal wall becomes rigid. The importance of giving an anæsthetic is well illustrated in the case, in which no tumour is noted. When admitted into the ward he was thought to be suffering from appendicitis; at any rate there was a history of three days' vomiting, great pain in the abdomen, and constipation; but there was no history of the passage of blood or mucus from the bowel, and

the chief pain and tenderness were over the right iliac fossa. Operation was accordingly performed for appendicitis, but it was found that the tenderness in the right iliac fossa was due to intussusception. So the only case in which tumour was not noted was one in which an anæsthetic was not given. In all the other cases a tumour was felt, and in the majority of them under chloroform.

4. The fourth important symptom is *pain*, and that is noted in many of the cases, *i.e.*, nine out of the fifteen. Probably it was present in every case, but only in nine does it seem to have been great enough to make the mother lay stress upon it. The pain in intussusception is of a peculiar character; it occurs in paroxysms. The child may be perfectly quiet, even asleep, when it will suddenly wake up and scream. That is no doubt caused by recurrent periods of peristalsis; a wave of peristalsis may squeeze the intussusception and thus give rise to pain. If you examine the abdomen when the pain is beginning to come on, it can sometimes be noted that the tumour hardens, and after that the baby will begin to cry. Or, apart from that, if you are examining the tumour under an anæsthetic, when of course you cannot tell whether it is painful, you can make out every few seconds that the tumour hardens from a wave of peristalsis passing along it.

5. Another method of examination may help you, and that is rectal examination. Occasionally you will be able to feel the intussusception presenting in the rectum, and recognise the ileo-cæcal valve as the most advanced point; but in a great many cases the intussusception is not so far advanced as to be within the reach of the finger. However, it is a useful adjunct to the other points. Again, although you may not be able to reach the tumour with the finger, yet by bi-manual examination, with a finger in the rectum and the other hand on the abdominal wall, you may be able to recognise a tumour which otherwise you might have missed.

There are other symptoms, but they are not of such great importance as the preceding. The next I would mention is distension The longer the duration of the case before you see it, the greater will the distension tend to be. As in every other case of acute intestinal obstruction, the bowel tends to become paralysed above the obstruction, and in consequence of the paralysis it becomes dilated and filled with gas. As nearly all these cases commence in the cæcum, the whole of the small intestine is paralysed, or quickly becomes so, with the result that it will dilate, and cause considerable distension. But this distension is common to many diseases.

Rigidity of the abdomen is present in many cases, especially where there is much peritonitis, but this again is not peculiar to intussusception, it is very often a marked feature however.

In later cases, where the vomiting has been going on for some time, the expression of the child will be changed, the eyes becoming sunken and the face pinched. But I would ask you not to take much notice of that, or rather not to wait for symptoms of that kind before making a diagnosis. If you do not make your diagnosis before the child looks sunken and ill it is improbable that the result will be satisfactory.

With regard to the *diagnosis*, this is not at all difficult in the majority of cases, but it is possible to meet with considerable difficulties. Supposing a previously healthy child is brought to you with the history that it started vomiting suddenly, and soon afterwards blood was noticed in the napkin, and it seems to have attacks of pain, you ought certainly to suspect intussusception. If, with such a history, you find a tumour in the abdomen, you can be pretty certain that, with very rare exceptions indeed, you are dealing with intussusception.

With regard to the cases which may give rise to difficulty or doubt in diagnosis. As a rule, given the typical signs, it is not difficult to recognise intussusception. There is one rare disease, however, in which there may be extreme difficulty of differentiation, and that is Henoch's purpura. This malady usually affects children, and it is usually associated with spasmodic pain in the abdomen and hæmorrhages into the stomach or intestine. Frequently there is vomiting, and also the passage of blood per anum. Moreover, hæmorrhage may occur into the wall of the bowel and cause a tumour resembling an intussusception, or again, such a hæmorrhage may be the starting point of an actual intussusception. Thus you may have, in Henoch's purpura, all the symptoms of intussusception without intussusception, or this disease may be actually associated with intussusception. In such cases it may be impossible to be certain of the diagnosis without an abdominal exploration. I have only once had this difficulty myself, that was in a very interesting case of Henoch's purpura in which there was a large sausage-shaped tumour caused by hæmorrhage.

Now, I want to go rather fully into the question of treatment. There are two recognised methods of treating intussusception. One is by *inflation* of the bowel from the rectum and the other is by *laparotomy*.

Inflation consists in giving the child an anæsthetic, and by means of a funnel and tube, or by a special apparatus, injecting into the rectum a quantity of either milk and water, or normal saline solution, or air, the object being to so distend the bowel that the intussusception is gradually driven upwards and reduced A few years ago inflation was relied upon almost entirely, and only when repeated attempts had failed was the surgeon asked to intervene and open the abdomen in order to reduce the intussusception digitally. As you would expect, the operative results were then very bad, for the simple reason that though the patients were only tiny babies they often had several anæsthetics and inflations within a few hours, so that by the time the abdomen was opened they were practically hopeless. That is illustrated very well by the second case in my list. It was a baby five months old, who was taken into Clinical, and an anæsthetic given in order to make a diagnosis. Having made it the Clinical sent for the assistant physician. He gave another anæsthetic and proceeded to pump milk and water into the bowel. It was thought that after manipulation under the anæsthetic the intussusception was reduced. A few hours afterwards, however, the child passed some more blood and mucus and the tumour was again felt. So the assistant physician was sent for again and he once more recommended the injection of milk and water into the intestine. This was done and again the tumour seemed to disappear. A few hours later there was another return of symptoms and once more the tumour could be felt. Then I was asked to see the child. When I operated, therefore, that child had had four anæsthetics in twenty-four hours. The intussusception was perfectly easy to reduce; I do not think the operation took ten minutes, but the child died a few hours afterwards simply from shock and from the effect of the frequent anæsthetics.

I have collected several groups of cases showing the results of inflation. In four of the cases in my list inflation was tried, but it failed in all of them. Mr. Eve, in a paper on intussusception, published twenty-four cases of inflation, in all of which it was a failure. Mr. Barker published eight cases in which inflation was tried and failed, and in another collection of seventy-two cases it failed in 75 per cent. So you see that in the great majority of these cases inflation was a failure.

Let us now consider for a moment why inflation is a failure. In the first place sufficient force cannot be used safely, For after opening the abdomen it is often necessary to use very considerable force in order to reduce an intussusception of even only a few hours' duration, and it becomes quite clear that an equal amount of force could not be used as a distending force from below without causing rupture of the bowel In fact it has often happened that the bowel has been ruptured in the attempt to reduce an intussusception by inflation.

The next point is dependent upon the anatomical character of the intussusception. If the entire intussusception is below the ileo-cæcal valve it is possible to reduce it by inflation if sufficient force can be used; but it has been shown definitely that you cannot inject water or gas per rectum beyond the ileo-cæcal valve, and therefore if the intussusception extends higher than that, inflation must fail. And it is important to note, a propos of this anatomical fact, that a large proportion of the cases do start above the ileo-cæcal valve. The majority of intussusceptions I believe commence as enteric ones, at the lower end of the ileum, and subsequently push in front of them the ileo-cæcal valve, which becomes the apex of what is apparently an ileo-cæcal intussusception. If you inflate such an intussusception you can reduce it as far as the ileo-cæcal valve, and the tumour may have apparently gone. But the small enteric part of the intussusception has been left, and that will start the process all over again, and in a few hours there will be a return of the symptoms.

Let me now just recapitulate the *objections to inflation*. First of all, it is uncertain, as you can judge from the figures I have given you. The patient's life depends on the careful treatment of these conditions. They are small babies who cannot stand very much, and it is certainly unwise to use a method of treatment which has as much uncertainty about it as this has. There is therefore the danger of loss of very valuable time, with the result that you may lose a case which otherwise might have recovered.

Secondly, there is the danger of rupture of the intestine.

Thirdly, there is the danger of the condition I have just mentioned, namely, apparent reduction.

Finally, inflation is unscientific, because you cannot accurately follow its action; you do not know for certain what effect you are producing. For these reasons, I say, inflation is not to be relied upon.

The second form of treatment consists in opening the abdomen, under all conceivable

aseptic precautions of course, and reducing the intussusception with the fingers. Or what is known as the combined method may be used, *i.e.*, inflation at the same time as operation. But the disappearance of the tumour must be *no* excuse for not opening the abdomen.

What I do is to have an anæsthetic given to the child and the abdomen prepared for the operation, and then a tube is introduced into the rectum, and salt and water injected, while the abdomen is carefully kneaded. If the tumour is on the left side, it usually recedes towards the right iliac fossa, and sometimes disappears altogether. In other cases it does not alter much.

Supposing it produces no effect at all, you are no worse off than you were before, and it has not occupied much time or necessitated an extra anæsthetic.

If the tumour has disappeared altogether, all that you need do, as a rule, is to make a small button-hole incision into the abdomen and put the finger in to make certain whether the intussusception has been completely reduced. I have done this on several occasions, but have each time found that the intussusception was not entirely reduced; there was a small enteric intussusception left. This was easily reduced.

If the tumour does not disappear, the next step is to open the abdomen and search for the intussusception. If it is in the middle-line, high up, it is as well to make the incision in the middle-line; but, as a rule, the best position is in the right linea semilunaris, because you will remember that the majority of intussusceptions commence in the right iliac fossa, so the last part of your manipulation will be in that region. Then with the finger the intussusception is felt for. Having found it, it is hooked up into the wound, and the reduction begun. This is done by grasping the tumour with pads, pressing firmly on the apex and pulling on the entering bowel at the same time.

Now the question as to how much force can be used arises? I think the answer lies in this: that supposing you give it up, and you conclude that the intussusception is not reducible, you can be almost certain that the child will die. Therefore you are clearly justified in using as much force as is necessary. If the bowel gives way the intussusception is clearly irreducible and must be resected and the ends of the intestine joined together. If you can reduce the intussusception without the intestine tearing across, all well and good. Sometimes in bad cases the muscular and peritoneal coats are torn through in half a dozen places or more. This does not apparently matter in the least. It certainly does not lead to peritonitis as might be expected, because many of the cases in which these tears have taken place have rapidly got well without a bad symptom, and in not one has there been any sign of peritonitis.

With regard to irreducible intussusception, the question arises as to what is to be done. The bowel having been torn across you must either tie in a Paul's tube and drain the intestine, or remove the whole intussusception. I have only had two cases of irreducible intussusception. In one I tore the bowel across, and in that case I performed resection and put in a Murphy's button, and the child died twelve hours afterwards. In the other case it would have been impossible to put in a Murphy's button because so much mesentery was drawn in that I could not get the intussusception out of the abdomen at all. I put in a Paul's tube and that child died in twenty-four hours.

So if you fail to reduce an intussusception through the abdominal incision the child will almost certainly die. There have been a few cases that have recovered, but they must be very rare.

With regard to the results, first of all in the fifteen cases I have here, there were four deaths. The first was the case I have already told you about, that in which inflation was tried twice before I saw it. I believe it would have got well had the abdomen been opened at once. In the second case there was sufficient to explain the death. It was very bad although of only twenty-four hours' duration. The abdomen was enormously distended, and I had to expose practically the whole of the intestines. Then the manipulation was a very long one, because it was extremely difficult to reduce. Death was no doubt due to exhaustion. She did not vomit, and the bowels were opened, but she did not sleep. Post-mortem, everything in the abdomen was found to be satisfactory.

The third case that died was a child that practically recovered from the operation, but died four weeks later from parotitis and septic bronchopneumonia. The fourth fatal case was the one in which a Murphy's button was introduced.

The death-rate in this series of fifteen cases was, then, 27 per cent., or, excluding the death from parotitis and bronchopneumonia, 20 per cent.

I have another collection of cases here, 187 in number, from a table given in the "Annals

of Surgery," and in them there was a death-rate of 57 per cent. I think that is too high, and that the death-rate nowadays is nearer 25 to 30 per cent. Of course, the less inflation is tried and the earlier laparotomy is performed, the more likely is treatment to be successful, since the actual risk of laparotomy is clearly much less than that of inflation.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Proposed Memorial in the Chapel.

DEAR SIR,—In reply to the question at the end of your note in the last number of the GAZETTE I may say that the cost of the oak work in the chapel will be about £60. This does not include the cost of the names on the roll.

We cannot say what the cost of the names will be for we do not know how many names there are. We propose to send a list to the GAZETTE in September and shall be glad of any corrections or additions from your readers. The *opus sectile* work in the recesses is a more expensive part of the plan. Each recess will cost £50, and there are eight of them. I am glad to be able to say that Mr. Hankey has very generously offered to defray the cost of two recesses, and that the Treasurer, Lord Ashcombe and Mr. John Gilliatt have each sent £10, Sir Frederick Wigan £5 and Mr. Lushington £3 3s.

Any subscription, large or small, will be received very gratefully and it would be an advantage to know early how much support we may expect.—I am, yours faithfully,

HARRY LE FANU.
(On behalf of the Chapel Committee.)

DEAR SIR,—May I say how glad I was to read the Rev. Henry Le Fanu's letter, *re* the above, in your last issue.

I would like to see the scope of Mr. Le Fanu's excellent idea still further widened, and a Roll of Honour instituted. We are proverbially a narrow-minded profession, and the horizon of our mental vision is too often bounded by the worth of the £ s. d. capacity both in others as in ourselves.

Most certainly professional fame should be the first aim of all medical students; but as one grows older, whether one succeeds in one's profession or not, there is an indefinable something else to be acted up to as well. It is the perpetuation of the memory of men and women who have acted up to this indefinable something which constitutes the *esprit de corps* of an institution.

I fear I cannot put my ideas very intelligibly, but the following heterogenous list of names that I would like to see inscribed on the Roll of Honour may make my intentions clearer:—

ARTHUR DURHAM.
JOHN KEATS (the Poet).
WM. J. MAILLARD (the only Naval Surgeon who has won the V.C.).
MRS. KEOGH (for years Night Nurse in the Surgery).
— WARE (P.M. Man for many, many years).
MISS COTTON.

These names suggest themselves to me at the moment of writing.

I think Guy's should teach that her history does not entirely depend upon the West End and lucrative practice.—Yours faithfully,

GERALD SICHEL.

The Biennial Dinner.

DEAR SIR,—Another Biennial has passed. Like others it has been chronicled as, and probably was, very successful. But it was not the success it ought to have been. I was not there, and I am one of the multitude, and I know several others in this neighbourhood that were not present. What is more we do not stop to enquire if others of us went up. We ought to. If there was the keenness, the enjoyment there should be, we should stop to discuss it. It is a sad thing to hear a man say, "No! Guy's knows me no more. I went up there and no one knew me. The place has been altered. I hardly knew the way about;" but I have heard it said several times. What could they expect. Times change, you can't keep officials to recognise and welcome old Guy's men? and yet the pity of it? Bear with me a little and see if I can reduce the intangible sentiments some of us feel to black and white. "Why don't you go to Guy's more often and keep up your associations?" "Because we are strangers in the land." "Then why not go to the Biennials so that you may not be strangers?" "Because talking to a stranger for an hour or two once in two years won't make us otherwise." I think that is the feeling that many have. Can anything be done to remove it? Stage management, organization, attention to details may do something. In the first place, consider the summons to dinner. It comes from the authorities, the powers that be, nothing in which you have any elective or other relation. Sometimes it bears the signature of a man you have never seen. Someone who came to Guy's and has made a great career since you went down. Instead of calling up old memories, of calling on your youth to come back again, it shuts the door on it; the name tells us we are old, we belong to an unknown generation; we are called to be social and jovial and remember old times by whom? A stranger. Is this wise?

The summons to this year's dinner bore a name I knew well. ——— was the best man of my generation; clever, a gentleman, and good looking. (Some

youngster will laugh at that attribute. I should have done so. Wait—You will see some day that the looks of your companions affected you more than you were aware of.) On receiving a summons from ——— I meditated a suitable letter to a friend one has not seen for nearly a quarter of a century, when my attention was caught by the note: "It will greatly facilitate the secretarial work if you will answer on the card enclosed" (or words to that effect). I complied with the request and tried to realise once more that I am but a foraminifer, the bodies of a few thousand like me go to form a piece of chalk that a boy will one day throw in a pond.

Another point, of more importance than the little detail I have just mentioned, is the oratory at the dinner. We have one or two good speakers on the consulting staff, by all means let us hear them when convenient to them, but why insist on some revered teacher making an after-dinner speech when he is aware that he cannot do it. It is the tyranny of ceremonial that hag-rides all social functions in England.

I have pointed out one or two slight faults in the present administration of the Biennial, can I suggest any improvement? The Secretary evidently worked hard for the success of the dinner. It was recognised, and he also suggested the line of improvement. I propose that each fifth year the students should be asked to organise themselves into a club and appoint a secretary and president for the year, all men who have joined the hospital within that five years being *de facto* members. On the occasion of the festivals the secretary approaches them by circular letter, and takes in hand all the arrangements of his table. At the 1st of October dinners a certain number of tickets—say five to old years, twenty for more recent ones—might be assigned to the quinquennial secretaries, who would try to get them taken up.

Further developments of such a scheme might be worked out, but I will submit it at once to your readers that the opinion of past and present students may be sought. I will ask any who read it to take the trouble to write a post card to the Editor saying I am in favour of (or opposed to) the scheme sketched by

HAKIM.

Notice.

THE BEANEY SCHOLARSHIP IN MATERIA MEDICA.

The Beaney Scholarship in Materia Medica will shortly become vacant. The Scholarship, open to candidates who have received part at least of their medical education at Guy's Hospital, is of the annual value of £30, and is tenable for three years. Further particulars may be obtained from the Dean, to whom applications must be addressed, at the Medical School Office, not later than October 3rd, 1904.

In Lighter Vein.

THE CONFESSIONS OF VEREUNSAEFF, THE PHYSICIAN.

INTRODUCTORY NOTE.

The publication of these Confessions has been received with so much approbation both from Press and Public that the publishers are emboldened to go one better. "The Confessions of an Accoucheur" is already in the press and will, it is hoped, be on the market before the Censor wakes up. The work has been entrusted to a well-known ladies' doctor; it is written in the Lancashire dialect, but an English translation is being prepared. The work will contain many of the Author's "own idees." No effort has been spared to make it entirely unsuitable for the lay reader, and every page bristles with revolting details. The *edition-de-luxe* will be found specially suited for New Year's Gifts and Christening Presents.

THE PUBLISHER.

INTRODUCTORY NOTE TO THE ENGLISH TRANSLATION.

These Confessions made their initial appearance in the well-known Russian monthly, *Mir Bogey* (a sort of Girls' Own Paper), and from the outset created a deep sensation. So much so, that there is no exaggeration in the statement, that at one time the reading public was divided into two parties—those who had read the book, and those who had not. This translation has been prepared for the benefit of those who, preferring the study of modern languages, omitted to learn Russian when at school. While preserving the full-blooded flavour of the original, the translator has thought well not to follow the Russian text too slavishly.

The earnest student may discover a very inferior joke in the preceding sentence, but this is guaranteed to be the only touch of humour in the book.

THE TRANSLATOR.

PREFACE.

"Has anybody seen our cat?"—ALFRED AUSTIN.

The publication of these Confessions has brought down on me a storm of abuse. How had I the hardihood to give the game away? What could my aim have been? Ought I not

to have known better? In fact, *cui bono?* For the answer to all these questions the reader is referred to my banking account. It has been my endeavour simply to present bare facts and to leave the truth without a stitch of clothing.

THE AUTHOR.

P.S.—In view of the inquiries that have been addressed to me, I think it necessary to explain that those parts of my "Confessions" which are not facts are fictitious.

INTRODUCTION.

The amount of preliminary canter to this book will have prepared the reader for the statement that I am a bad starter. In truth I began life badly, for I was born without any sense of proportion. When I was but a few weeks old the nurse upset the perambulator and my anterior fontanelle came into violent contact with the curbstone. This fact was made light of at the time (especially by the nurse), but it explains much that is to follow.

I am but a practitioner of average intelligence and ability. In Russia the average is low.

As my publisher positively refuses to admit any more Notes, Prefaces or Introductions, I am now about to begin.

CHAPTER I.

The first two years at the Faculty of Medicine are devoted to the study of the various branches of natural science. So engrossed was I by these subjects that I continued to study them for seven years. During this time I frequently met the leading lights of the profession, who were so impressed by my singular views that they always invited me to meet them again in periods varying between three, six, and nine months.

Every day, every lecture brought new "discoveries" in their wake. I was astounded to learn, for instance, that beef-steaks were made of "muscle," which hitherto I had imagined to be cartilage; formerly I had thought that solid food left the stomach for the intestines and fluid for the kidneys. Now I know that it is the other way about. Afterwards I learnt that many so-called educated people are ignorant of this simple fact.

When studying anatomy I was pained and shocked at first to find that all the subjects for dissection were dead; but I soon became quite familiar with the corpses, and spent many a pleasant hour with them, affably discussing their home life.

When walking in the street watching a pedestrian in front of me, I saw in him but an animated corpse. Once he dropped his walking-stick, and I was deeply interested to see him pick it up with his *musculi recti abdominis.* People who were near and dear to me assumed a dual personality; that young girl, for instance, that I used to walk out with and discuss anatomy and things—there is so much originality about her, and yet, after all, she would be a very unpleasant subject to dissect—there is so much fat about her. One night I mentioned the matter to her. She walks out with someone else now.

CHAPTER II.

At the end of seven years my clinical work began. From this time onward the character of my knowledge underwent a radical change. I found to my horror and disgust that people came to the hospitals because they were ill, and not because they liked it.

The mere fact of the existence of suffering was not the most terrible side of the question; the ease with which it could be acquired was what appalled. In our clinique was a young government clerk whose suffering dated from one fine summer evening when he had sat down on the dewy grass.

Disease is everywhere, and it is no good trying to dodge it. Decay lies hidden in man from the tenderest age and even before that. In Boston it was found that children who had a single milk-tooth remaining after the age of twenty were *the exception.* Only the labouring classes can dispense with the use of a pocket handkerchief. Some men go bald and others have tenor voices. There are more people dead than living, and few of them are aware of this simple fact.

CHAPTER III.

I remember the first confinement at which I was present as if it had occurred but yesterday.

My landlady's cat came home one evening looking rather sheepish, and wandered upstairs in the direction of my bedroom. I thought no more of the circumstance till I was awakened in the night by agonized and almost human cries. Striking a light, I was at first unable to determine whence the disturbance came, till a sound more piercing than all that had gone before directed my attention to my new silk hat. There I discovered that the poor creature had deposited a litter of six kittens.

This was quite normal too. In thousands of years civilization has not been able to improve on the methods of the ancients.

CHAPTER IV.

I had not gone very far in my studies before I discovered that I myself was a walking mass of disease. I began to notice that something abnormal was taking place within me: I experienced a general distaste for work, and my thirst grew out of all proportion to my appetite. I was terror-stricken. I carefully examined my nervous system and found that I had Friedrichs' Ataxy complicated with suppressed Syringo-myelia. By tying my foot to the bedpost and then falling out of bed I was able to elicit Kernig's sign. All this seemed bad enough, but one day I distinctly detected the symptoms of Pseudo-hypertrophic Pulmonary Arthropathy. At first I thought it was measles, but I knew that you seldom get measles twice and I had had it when a boy. A week afterwards I found that I was sickening for Glénard's disease.

I went to our professor of therapeutics. I did not tell him my diagnosis as I did not wish to prejudice his judgment. I simply detailed my symptoms.

He cut me short.

"Vereunsaeff," he said, not unkindly, "take my advice. Go home and bury yourself."

* * * *

CHAPTER V.

I pass over the many remaining years of my student life, nor will the space at my disposal permit of a description of the ignorance and prejudice displayed by the examiners in medicine on divers occasions. By an oversight on their part I finally became qualified to practice, and set up my plate in a populous district—advice and medicine, six kopecks. I had been there six months without seeing a patient, when one day there was a ring at my surgery bell. A panic fell upon my mind. All my knowledge seemed to leave me, all my faculties seemed to be paralysed. What should I say to my patient, what should I do? Before entering my surgery I hastily swallowed a bottle of vodka, and refreshed my memory from the standard Russian text-book, "Lightning Diagnosis, or How to tell a patient's disease from the colour of his necktie."

Thus fortified I proceeded to the consultation. With a show of bravado I went up to my patient and said, "Let me see your pulse, that is, I should say, let me feel your tongue." I felt that I was getting hopelessly confused. With a great effort I calmed myself and asked a rational question. "Tell me," said I, "how many polymorphonuclear leucocytes have you to the square millimetre, or don't you talk French?"

"I don't know what you are talking about," was the reply. "What I came for was the water rate."

When I regained consciousness he had gone.

Shortly after this incident I was called into the country to see a sick child. I made a careful examination, and was able to reassure the anxious parents.

"Have no fear," I said, "in a very little while your child will be perfectly well."

Next day the father called round for the death certificate. Fortunately he was wearing his snow shoes.

My next important case was a confinement. I had been with my patient twelve hours without much progress being made, but as I had adopted as my motto "Slow, but accoucheur," I determined not to interfere. But when after another twelve hours the condition remained the same, it became evident that something must be done, but what? Should I apply a vectis or a cephalotribe? The books are silent on these practical points. *I do not blame the books, they cannot allow for* every contingency.

I had left my instruments at home, and my home was twelve versts away, so after speaking a few words of comfort to the patient I started home for my instruments. When I returned I was informed that another medical man had been called in, and had diagnosed dyspepsia. I was not asked to call again.

One evening I was called to see a man who had a pain in his knee-joint. He explained that he sent for me because all the other docters were out. I diagnosed "Arthritic dolor" and sent him round some liniment. When I called to see him next day I found him unable to speak, and in a critical condition.

"Come, Ivan Ivanovitch Ivanowsky," I cried, calling him by his pet name, after the Russian custom, "tell me what ails you?"

"I don't think your medicine agrees with him, doctor," said his wife.

"Medicine! What medicine?"

Then my eye fell on the bottle of liniment. I had inadvertently labelled it "The Gargle!"

Such mistakes are happening every day, every hour. But is the medical profession to blame for them? No; emphatically no! It is the system of medical education that is alone to blame.

CHAPTER VI.

Next week I am going on to the Stock Exchange.

A. A. M.

NOTE.—In this form the above MS. passed the Russian Press Censor. An unexpurgated edition can be obtained in Berlin and at 4, St. Thomas's Street, S.E.—ED.

Revised Syllabus for L.D.S. Examination.

BY R. P. ROWLANDS, M.S.

ANATOMY.

All the bones, but the small bones of hand and foot are not important.

All the anatomy of the head and neck, but only an elementary knowledge is required of the brain, cord, eye, and ear.

An elementary knowledge sufficient to understand the physiological actions of—

(*a*) All the thoracic and abdominal viscera, especially heart, lungs, stomach, and intestines.

(*b*) The large joints, especially the knee, and sterno-clavicular.

(*c*) The muscles producing the main movements of the body, especially the muscles of the upper limb, and those used in dental operations.

(*d*) Course of large vessels and nerves.

PHYSIOLOGY.

Foodstuffs.—Nature of proteids and gelatin, fats, carbohydrates, salts, and water. Digestion and absorption of these. *Composition of* milk, meat, bread, butter, potatoes, soup, beef-tea.

Salivary glands.—Structure at rest and in activity, nerves, composition and uses of saliva, ferments organised and unorganised. Mastication and deglutition.

Stomach.—Structure, gastric juice and its uses, vomiting. Pancreas: structure, secretion and its uses.

Liver.—Structure of lobule, circulation, bile-ducts, gall-bladder. Glisson's capsule. Bile and its uses. Glycogen.

Intestines—structure, valvulæ conniventes, structure of villus; secretion, actions; peristalsis, colic, diarrhœa; naked-eye appearances of different parts; course of food from mouth to anus; defæcation.

Absorption of food and course into the blood of each variety.

Lymph and chyle — receptaculum chyli, lacteals, thoracic duct.

Respiration—internal and external—structure of lungs and trachea, pleura; movements of chest and how produced; nerves and nerve centres of respiration; changes in larynx during breathing; cough; capacity of lungs, tidal air, etc., dyspnœa, apnœa; differences between inspired and expired air, and between arterial and venous blood; diffusion of CO_2 and O_2, condition in the blood. Ventilation; structure and uses of nasal mucous membrane.

Circulation—Blood.—Constituents, corpuscles, plasma, coagulation; structure of heart and blood vessels; actions of heart, cardiac cycle, peripheral resistance, blood-pressure, velocity of blood; pulse, pulse tracing, velocity, rate; bleeding from vein, artery and capillary; nerves and nerve centres for heart and vessels. Aids to circulation (1) respiratory movements, (2) valves, (3) contraction of muscles; fœtal circulation.

Nervous system.—Structure of nerve cells and nerve fibres, reflex arc, reflex action, examples, structure of white and grey matter (of brain and cord); paths of sensory and motor impulses; uses of differents parts of brain and cord.

Excretion by kidneys.—Structure, urine composition, urea, micturition.

Excretion by skin.—Structure, sweat, uses.

Excretion by lungs, intestines, etc.

Body heat.—Production, loss, regulation, warm and cold blooded animals, temperature.

Muscles.—Structure, uses as producers of movement and heat; phenomena of contraction.

Special Senses.—Brief account of the mechanism of each special sense.

SURGERY.

Inflammation.—Phenomena, results; acute abscess, its wall, pus, ulceration, cellulitis, sloughing, gangrene, necrosis, boils, carbuncles, styes, sinus, fistula; general characters of fever.

Wounds.—Kinds, wound infection micro-organisms and their action; sapræmia, septicæmia, pyæmia, erysipelas, tetanus, aseptic treatment of wounds.

Repair.—Various methods in detail.

Hæmorrhage.—(1) Primary kinds, natural arrest, and repair of vessel; artificial arrest; arrest of bleeding from mouth, tongue, tonsil, lip, tooth-socket, nose and varicose veins; (2) Reactionary; (3) Secondary, causes, treatment, effects of hæmorrhage, treatment of anæmia; hæmophilia and other bleeding diseases; scurvy.

Syphilis acquired and congenital (thoroughly).

Aneurysm and cirsoid aneurysm.

Tumours.—(*a*) Innocent; (*b*) Malignant; i. Connective tissue; ii. Epithelial; Especially—epithelioma, carcinoma, sarcoma, rodent ulcer, fibroma, myxoma, osteoma, wart and nævus. *Cysts*—hydrocele, sebaceous, and dermoid.

Diseases of the Tongue.—Wounds, acute glossitis, chronic superficial glossitis, thrush. Ulcers of tongue and mouth; simple, mercurial, tubercular, syphilitic, malignant; Tumours—Excision of tongue.

Diseases of the Salivary Glands.—Ranula, salivary calculus and fistula; mumps; tumours.

Ganglion, eczema, ringworm, scabies, impetigo, cystitis, chilblains, lupus.

Diseases of bone.—Periostitis, osteitis, necrosis, acute infective necrosis, or osteomyelitis, caries, rickets, growths, osteoma, exostoses (ivory and cancellous), sarcoma (central and peripheral), odontomata, excision of jaws. Actinomycosis.

Syncope and shock.

Concussion and compression of brain, meningeal hæmorrhage, fractured base.

Fractures.—Signs, treatment, process of healing, treatment of fractures of jaws, dislocation of lower jaw.

Anæsthetics.—Choice, risks, foreign bodies in air passages, laryngotomy, tracheotomy, cut throat, foreign bodies in œsophagus.

Cleft palate and hare-lip.

Diseases of lymphatic glands, septic, tubercular, and malignant, and Hodgkin's disease.

Adenoids, nasal and nasopharyngeal polypi.

Diseases of the maxillary antrum.

Tonsillitis, diphtheria, retro-pharyngeal abscess, alveolar abscess, fixation of lower jaw (causes and treatment).

Diseases of joints, especially tubercular.

Otitis media and its complications.

Ophthalmia. Keratitis.

Epulides.

Results of section of a nerve trunk.

Scald of larynx, œdema of glottis.

Burns.

Hernia.

Hæmorrhoids.

Books recommended are—

Kirke in Physiology.
Walsham in Surgery.
Gray in Anatomy.

Change of Address.

Dr. A. Chaning-Pearce, from Chelmsford Street, Chartham, to 5, Lion Hill, Ramsgate.

Ludlow Strangways, L.D.S., from "Southernhay" to "Tor Grange," Newton Road, Torquay.

Dr. William F. Clarke, from 2, Baron's Court Road, West Kensington, London, W., to "Woodend," Beech Avenue, Balmy Beach, Toronto, Canada.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Evolution in its Relation to Comparative Odontology.

A paper read before the Dental Society in December, 1903, by C. Doswell Wallis, L.D.S. Eng.

Gentlemen,—The subject which we have under consideration this evening, is so vast that I cannot hope to deal with it at all adequately or at any great length. All I hope to be able to accomplish is to draw your attention to this very interesting subject, and perhaps to induce its further pursuit.

It may most conveniently be treated under the following headings :—

a. Evolution of animals in general on the principle of natural selection.

b. 1. Evolution of some curious dental armatures.

2. Evolution of a few of the more complex tooth forms.

Firstly, it is essential for us to have a clear idea of what Darwin's theory of the origin of species really was. Briefly it may be summed up as :—*Descent with modifications, which are inherited, and the survival of the fittest.* This theory will, however, be clearer if I quote to you some extracts from his works. Writing on this subject he says :—

"If under changing conditions of life organic beings present individual differences in almost every part of their structure, and this cannot be disputed ; if there be, owing to their geometrical rate of increase, a severe struggle for life at some age, season or year, and this certainly cannot be disputed ; then considering the infinite complexity of the relations of all organic beings to each other and to their conditions of life, causing an infinite diversity in structure, constitution and habits to be advantageous to them, it would be a most extraordinary fact if no variations had ever occurred useful to each being's own welfare, in the same manner as so many variations have occurred useful to man. But if variations useful to any organic being ever do occur, assuredly individuals thus characterised will have the best chance of being preserved in the struggle for life ; and from the strong principle of inheritance these will tend to produce offspring similarly characterised. This principle of preservation, or the survival of the fittest, I have called 'Natural Selection.' It leads to the improvement of each creature in relation to its organic and inorganic conditions of life, and consequently in most cases to what must be regarded as an advance in organisation. Nevertheless, low and simple forms will long endure if well fitted for their simple conditions of life.

Natural selection, on the principle of qualities being inherited at corresponding ages, can modify the egg, seed, or young, as easily as the adult. Amongst many animals sexual selection will have given its aid to ordinary selection by assuring to the most vigorous and best adapted males the greatest number of offspring. Sexual selection will also give characters useful to the males alone in their struggles or rivalry with other males, and these characters will be transmitted to one sex or to both sexes according to the form of inheritance which prevails. It may metaphorically be said that natural selection is daily and hourly scrutinising, throughout the world, the slightest variations, rejecting those that are bad, preserving and adding up all that are good ; silently and insensibly working, whenever and wherever opportunity offers, at the improvement of each organic being, in relation to its organic and inorganic conditions of life. We see nothing of these slow changes in progress until the hand of Time has marked the lapse of ages, and then so imperfect is our view into long past geological ages that we can see only that forms of life are now different from what they formerly were.

"If, then, animals and plants do vary, let it be ever so slightly or slowly, why should not variations or individual differences, which are in any way beneficial, be preserved and accumulated through natural selection, or the survival of the fittest ? If man can by patience select variations useful to him, why, under changing and complex conditions of life, should not variations useful to Nature's living products often arise and be preserved or selected ? What limit can be put to this power, acting during long ages and rigidly scrutinising the whole constitution, structure and habits of each creature—favouring the good and rejecting the bad ? There seems to be no limit to this power, in slowly and beautifully adapting each form to the most complex relations of life. The theory of natural selection, even if we look no farther than this, seems to be in the highest degree probable.

"Organs in a rudimentary condition plainly show that an early progenitor had the organ in a fully developed condition, and this in some cases implies an enormous amount of modification in the descendants. Throughout whole classes various structures are formed on the same pattern, and at a very early age the embryos closely resemble each other. Therefore I cannot doubt that the theory of descent with modification embraces all the members of the same great class or kingdom. I believe that animals are descended from at most only four or five progenitors and plants from an equal or lesser number. Analogy would lead me one step further, namely, to the belief that all animals and plants are descended from some one prototype. But analogy may be a deceitful guide. Nevertheless, all living things have much in common, in their chemical composition, their cellular structure, their laws of growth, their liability to injurious influences, &c.

"The affinities of all beings of the same class have sometimes been represented by a great tree. The green and budding twigs may represent existing species, and those produced during former years the long succession of extinct species. At each period of growth all the growing twigs have tried to branch out on all sides, and to overtop and kill the surrounding twigs and branches, in the same manner as species and

groups of species have at all times overmastered other species in the great battle for life. The limbs divided into great branches, and these into lesser and lesser branches, were themselves once, when the tree was young, budding twigs; and this connection of the former and present buds by ramifying branches, may well represent the classification of all extinct and living species in groups subordinate to groups. Of the many twigs which flourished when the tree was a mere bush, only two or three, now grown into great branches, yet survive and bear the other branches, so with the species which lived during long-past geological periods, very few have left living and modified descendants. From the first growth of the tree, many a limb and branch has decayed and dropped off; and these fallen branches of various sizes may represent those whole orders and genera which have now no living representatives and which are known to us only in the fossil state. As we here and there see a thin straggling branch springing from a fork low down in the tree, and which by some chance has been favoured and is still alive on its summit, so we occasionally see an animal, like Ornithorynchus or Lepidosyren, which in some small degree connects by its affinities two large branches of life, and which has apparently been saved from fatal competition by having inhabited a protected station. As buds give rise by growth to fresh buds, and these, if vigorous, branch out and overtop on all sides many a feebler branch, so by generation it has been with the great Tree of Life, which fills with its dead and broken branches the crust of the earth, and covers its surface with its ever-branching and beautiful ramifications." (*Origin of Species.*—Darwin.)

When we come to consider the various orders, classes and genera, we find that really no very great gaps exist, especially if we take extinct forms into account; and there can be no doubt that if our knowledge of geological remains were more perfect, the gradations would be even more obvious than they at present appear.

In the animal kingdom although the vertebrates and invertebrates are quite distinct, yet an intermediate link is to be found in that curious little animal Amphioxus (Lancelet) which has its skeleton notocordal and membrano-cartilaginous; possessing neither vertebræ, ribs or jaws; no brain or heart, the function of this latter being carried out by a pulsating sinus.

Somewhat bridging the gap between fish and amphibians we find amongst the Ganoid fish the Dipnoi (or double breathers) *e.g.* Ceratodus and Lepidosyren.

The members of this curious sub-class possess an air-sac (*i.e.* swim-bladder) with a pneumatic duct as in other Ganoids, but unlike them this duct opens by two pairs of nostrils placed inside the mouth; so that they can breathe either by their gills, or by this lung-like sac, or by both simultaneously. Their fins also are modified, so as to form what are obviously (according to Sir Richard Owen) very rudimentary limbs; although Dr. Günther considers that they are only remnants consisting merely of the central axis of a fin. In fact, so alike are these two classes that Professor Huxley groups

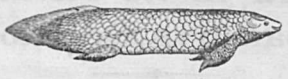


FIG. 1.

FIG. 2.

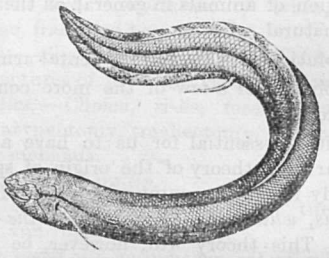


FIG. 3.

FIG. 1.—Ceratodus (the Barramunda). (From Brit. Mus. (Nat. Hist.) Guide Book.)

FIG. 2.—Mouth of Ceratodus. n n Narial openings. ⨯ Vomerine teeth. ⨯ ⨯ Palato-pterygoid teeth. ⨯ ⨯ ⨯ Mandibular teeth. (From Brit. Mus. (Nat. Hist.) Guide Book.)

FIG. 3.—A Ganoid Fish (Lepidosiren).

them together as one, the "Ichthiopsida"; and Sir Richard Owen states, that the presence or absence of nostrils (as separate from the mouth) is the only feature by which they may be absolutely distinguised. It may be well to note here that the Ganoids are in many respects intermediate between the Plagiostoma (sharks and rays) and the more common Teliostean (or bony) fish. Their skeleton and jaws are more perfectly ossified than in the sharks, and although some species have a heterocercal tail (*i.e.* consisting of two unequal lobes) as in the Elasmobranchi; yet several possess a homocercal tail (*i.e.* one consisting of two symmetrical lobes) like that of the true bony fish.

Turning to reptiles, we see that they are closely connected to the amphibia; the newts, *e.g.*, and some of the limbless batrachians being very reptilian in their characters; in fact, in the earlier part of their lives (*i.e.* whilst they have gills) batrachians may be almost considered to be fish, whilst in their subsequent existence (when they develop lungs) they may be looked on as being practically reptiles.

Again, from the study of fossil forms it is not difficult to understand how birds may have been evolved from saurians; indeed, "birds are," as Prof. Huxley has said, "animals so similar to reptilia in all the most essential features of their organisation that they may be considered to be merely an extremely modified and aberrant

reptilian form." In an ancient extinct class of reptiles, the Pterosauria (flying-lizards) we find many bird-like

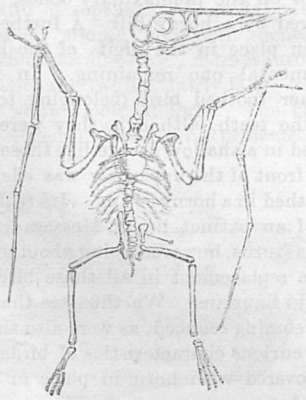


FIG. 4.—Skeleton of Pterodactylus spectabilis (two-thirds nat. size). (From Brit. Mus. (Nat. Hist.) Guide Book.)

characteristics, the members of this class possessing a keeled sternum similar to that of birds, also pneumatic bones (*i.e.*, filled with large air cavities) the walls of which were very thin, but their substance hard and compact, thus combining lightness with strength. But

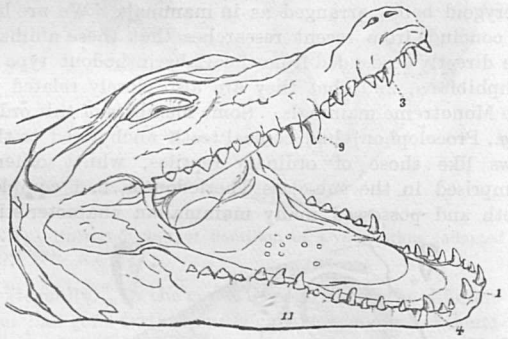


FIG. 5.—Head and mouth of Crocodile, showing teeth. (After Tomes.)

perhaps the most striking feature of these creatures was the enormous elongation of one finger of the hand which

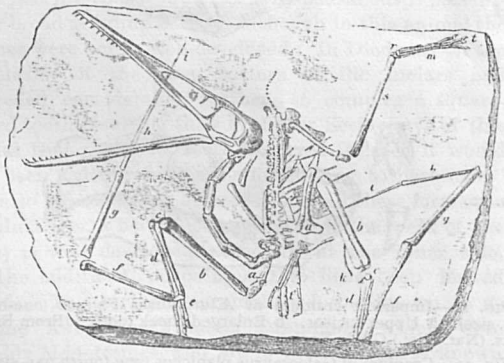


FIG. 6.—Skeleton of Pterodactylus antiquus (one-third nat. size, showing dentition. f g h i Phalanges of ulnar digit. e Small clawed digits. (From Brit. Mus. (Nat. Hist.) Guide Book.)

gave support to a wing-membrane, probably without feathers like that of a bat; the other fingers were short and furnished with claws; the teeth were all alike, conical and socketed as in some reptiles. In reptilia the teeth are simple recurved cones anchylosed to the bone in most genera, but in a few, *e.g.*, Crocodylia, they are socketed, similarly to those of the Pterodactyls and toothed birds. Thus Pterodactylus antiquus had socketed recurved teeth in most respects like those of the reptilia, the replacement being precisely similar, new successional teeth being constantly formed at the sides of the bases of the older teeth, which becoming absorbed made way for their successors to take their place. Pterodactylus Spectabilis was in most respects similar to Pterodactylus antiquus, but had no teeth, the margins of its jaw being,

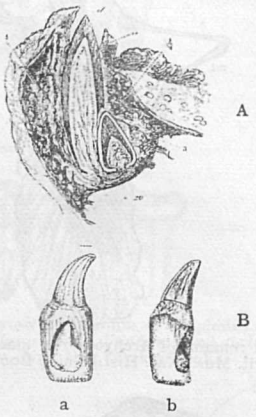


FIG. 7.—A. Transverse section of jaw of Aligator to show succession of teeth. (After Tomes.) B. Teeth of (a) Hesperornis Regalis with successional tooth in cavity at base (five times nat. size), and (b) Mossasauras princeps (one-third nat. size). (After Marsh.)

probably, sheathed in a horny bill like that of birds; this was also the case in many of the Pterosauria, for which Prof. Marsh has suggested the generic name of Pteranodon (*e.g.*, Pteranodon Longiceps). Some of these flying-lizards probably had an expanse of wing as much as from eighteen to twenty feet, whilst others were no

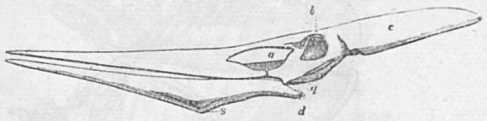


FIG. 8.—Skull of Pteranodon longiceps (one-eighteenth nat. size), showing edentulous bill. (From Brit. Mus. (Nat. Hist.) Guide Book.)

larger than a sparrow. There is no great gap existing between these reptiles aud the ancient toothed birds such as Archyopteryx Macrura, in which the hand is similarly modified, only two digits remaining in addition to the elongated one, and these, as in the Pterosauria, were furnished with claws. Archyopteryx had a long jointed tail (like a reptile), but from each joint sprung a pair of feathers; its wings were also covered with feathers. It was provided with numerous socketed teeth like those of the Pterosauria and some reptiles.

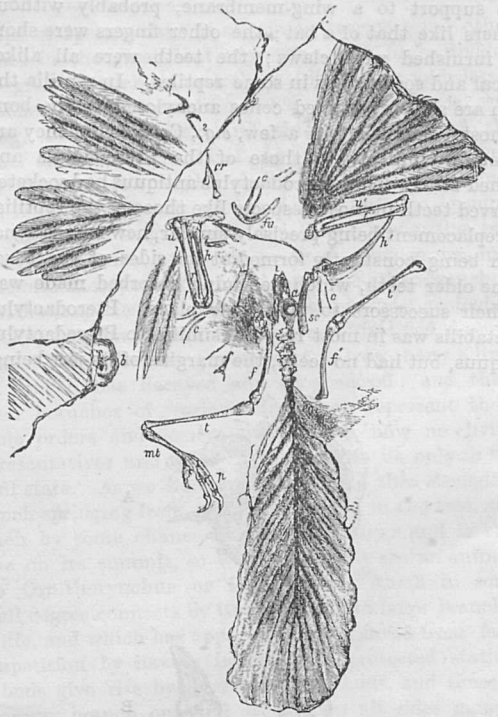


FIG. 9.—Fossil remains of Archyopteryx macrura (one-sixth nat. size). (From Brit. Mus. (Nat. Hist.) Guide Book.)

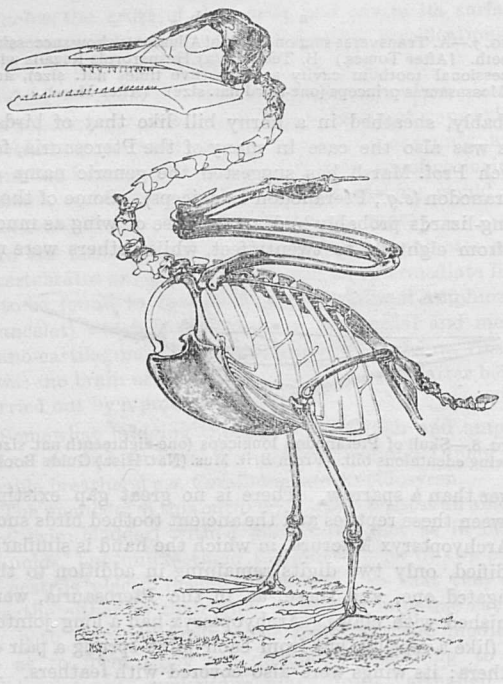


FIG. 10.—Skeleton of Ichthiornis victor, from specimens in Yale College Museum. (From Brit. Mus. (Nat. Hist.) Guide Book.)

Another of these primitive birds, Ichthiornis Victor (one of the Odontotornæ), had teeth implanted in distinct sockets, except on the premaxillary bones, which were probably covered by a horny bill. A further reduction had also taken place in the digits of the hand, only a small supplemental one remaining. In Hesperornis regalis, another toothed bird (belonging to the group Odontalcæ), the teeth, although they were numerous, were implanted in a shallow groove like those of Ichthyosaurus. The front of the upper jaw was edentulous and probably sheathed in a horny casing. Its teeth strikingly recall those of an extinct lizard, Mossasaurus princeps, those of Mossasaurus, however, being about sixteen times as large. The replacement in all these birds took place vertically, as in Saurians. We thus see that the useless digits were becoming reduced, as were also the teeth, and the two most curious characteristics of birds (viz., wings and a beak covered with horn in place of teeth) were being acquired.

It is also very probable that mammals branched off from reptiles, as is indicated by certain members of an order established by Sir Richard Owen and named by him the Anomodontia. These reptiles had their limbs adapted for walking and the same number of phalanges in each foot as in mammals. They had a double occipital condyle, the quadrate was fixed and palatine and pterygoid bones arranged as in mammals. We are led to conclude from recent researches that these animals are directly descended from the Labyrinthodont type of Amphibians, and that they are also closely related to the Monotreme mammals. Some members of this order (*e.g.*, Procolophon) had conical teeth anchylosed to the jaws like those of ordinary reptiles, whilst others, comprised in the sub-class Theriodontia, had complex teeth and possessed many mammalian characteristics

FIG. 11.

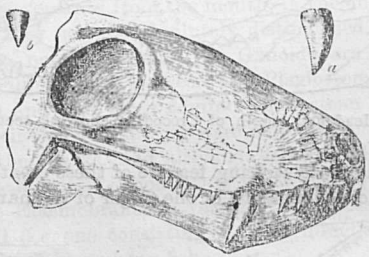


FIG. 12.

FIG. 11.—Imperfect cranium of Ælurosaurus Felinus (one-half nat. size). a Upper incisor. b Enlarged cheek tooth. (From Brit. Mus. (Nat. Hist.) Guide Book.)

FIG. 12.—Cranium of Galeosaurus planiceps (one-fourth nat. size). a Upper cheek tooth. b Incisor tooth. (From Brit. Mus. (Nat. Hist.) Guide Book.)

and are of particular interest in this connection; although all these animals retained the composite lower jaw characteristic of reptilia. All gradations are to be met with between simple homodont dentitions and complex heterodont forms;—*e.g.*, Ælurosaurus Felinus, had a large trenchant canine, fairly large incisors, but cheek teeth of simple conical form. The cheek teeth were better developed in Galeosaurus princeps, partaking

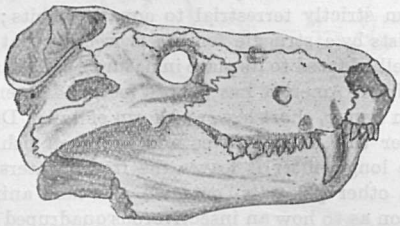


FIG. 13.—Skull and jaws of Cynognathus (adapted from Seeley).

more of the mammalian character, although the cusps were placed anteriorly and posteriorly, not internally

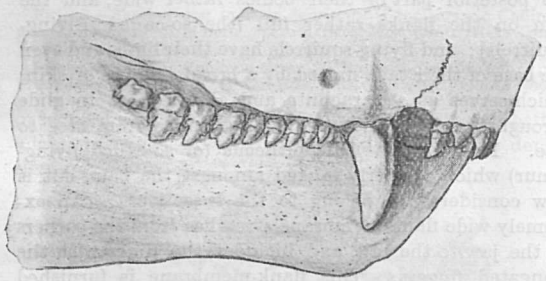


FIG. 14.—Enlarged view of dentition of Cynognathus (adapted from Seeley).

and externally. In the genus Cynognathus, the differentiation had gone farther and a carnivorous type of dentition arrived at; the incisors were cutting and increased in size from the middle line outwards, the canines were large and cutting and the cheek teeth worked on each other with a shearing action. In Empiedas Molaris the teeth had internally and externally placed cusps presenting a broad grinding surface, although in this animal the canines were not so well developed. In Diademodon the complexity of the cusp pattern of the molars had proceeded considerably further, so complex a square-topped tooth resulting that Professor Seeley says of this animal that "had its teeth occurred isolated it would have been legitimate to have referred them to mammals." It is also interesting to notice that in all these forms the cingulum (*i.e.*, a belt of enamel around the neck of the tooth) is well developed, especially at the inner side, and the additional cusps appear to have been derived from it. The earliest mammalian forms known to us are the American Jurassic Mammals which were probably Monotremes, and are in most instances known only by their jaws and teeth. As regards their general characters, they had for the most part smooth cerebral

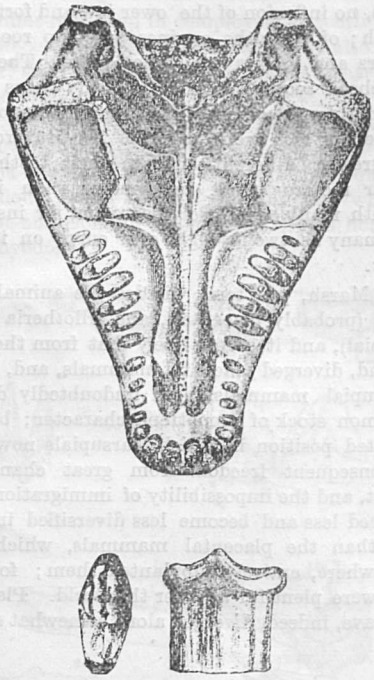


FIG. 15.—A. Palatal view of cranium of Empiedas molaris (one sixth nat. size). B. Enlarged mesial and occlusal surfaces of cheek teeth. (From Brit. Mus. (Nat. Hist.) Guide Book.)

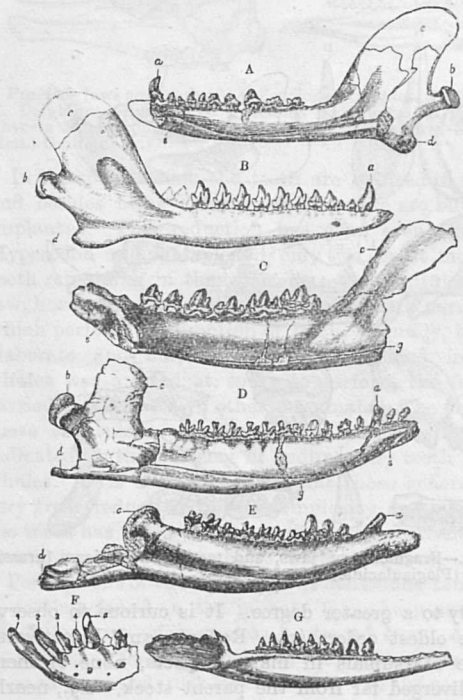


FIG. 16.—Mandibles and teeth of American Jurassic Mammal (Amphitheridæ and Spalacotheridæ). (From Brit. Mus. (Nat. Hist. Guide Book.)

hemispheres, no inflexion of the ower jaw and forty-four or more teeth; of these the canines had two roots and the premolars and molars were much alike. The usual pattern of cheek tooth was tricuspid, the cusps being placed anteriorly and posteriorly as in some Anomodonts. Some members of this group, *e.g.*, the Multituberculata, present a greater differentiation in their teeth than others, their molars being very mammalian in appearance with many cusps, Polymastodon, for instance, having as many as twenty-eight oval cusps on its first upper molar.

Professor Marsh, pro tem., divides the animals into Pantotheria (probably placental), and Allotheria (probably marsupial), and it seems likely that from these, on the one hand, diverged placental mammals, and, on the other, marsupial mammals, both undoubtedly derived from a common stock of monotrene character; but due to the isolated position in which Marsupials now exist, and the consequent freedom from great changes in environment, and the impossibility of immigration, they have advanced less and become less diversified in their characters than the placental mammals, which have indeed, elsewhere, entirely supplanted them; for once Marsupials were plentiful all over the world. Placental mammals have, indeed, diverged along somewhat similar

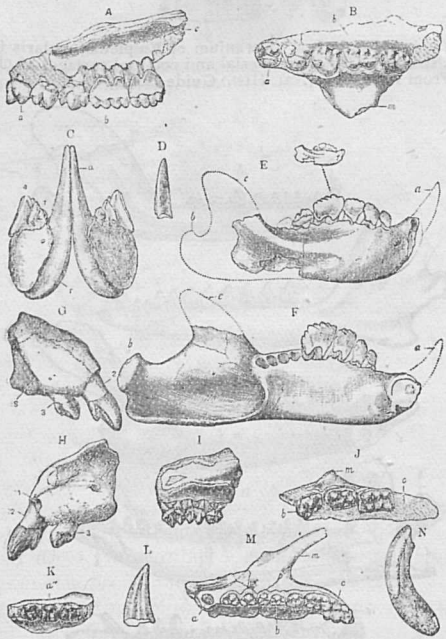


FIG. 17.—Fragments of jaws, and teeth of American Jurassic Mammals (Plagiaulacidæ).

lines only to a greater degree. It is curious to observe that the oldest orders (viz., Rodents and Insectivora) resemble Marsupials in many respects, none of them having diverged far from the parent stock,—*e.g.*, nearly all Marsupials have tubular enamel, as also do many rodents and some insectivores; also in their general characters these two genera closely resemble Marsupials, or perhaps rather their common Mesozoic ancestors. Amongst more modern mammalia it is perhaps difficult to understand how genera having aquatic habits could have been evolved or how they subsisted in the transitional state. This, and also the more puzzling question of the peculiarities of the Chiroptera, is thus discussed by Darwin, "It would be easy to show that there now exist carnivorous animals presenting close intermediate grades from strictly terrestrial to aquatic habits; and as each exists by a struggle for life it is clear that each must be well adapted to its place in nature; *e.g.*, Mustela Vison of North America has webbed feet, and resembles the otter in its fur, short legs, and form of tail. During the summer this animal dives and preys on fish, but during the long winter it leaves the frozen waters, and preys, like other pole-cats, on mice and land animals. The question as to how an insectivorous quadruped could possibly be converted into a flying bat is much more difficult to answer. Look at the family of squirrels; here we have the finest gradation from animals with their tails only slightly flattened, and from others with the posterior part of their bodies rather wide, and the skin on the flanks rather full (the so-called Flying-Squirrels); and flying-squirrels have their limbs and even the base of their tails united by a broad expanse of skin, which serves as a parachute and allows them to glide through the air to an astonishing distance from tree to tree. Now look at Galeopithecus (or so-called flying-lemur) which formerly ranked amongst the bats, but is now considered to belong to the Insectivora. An extremely wide flank-membrane stretches from the corners of the jaw to the tail, and includes the limbs with the elongated fingers. This flank-membrane is furnished with an extensor muscle. Although no gradated links of structure, fitted for gliding through the air, now connect Galeophithecus with the other Insectivora, yet there is no difficulty in supposing that such links formerly existed, and that each was developed as in the less perfectly gliding squirrels. Nor is there any insupperable difficulty in further believing that the membrane-connected fingers and forearm of Galeopithecus might have been greatly lengthened by natural selection, and this as far as the organs of flight are concerned would have converted the animal into a bat. In certain bats, in which the wing-membrane extends from the top of the shoulder to the tail and includes the hind legs, we perhaps see traces of an apparatus originally fitted for gliding through the air rather than for flight." (*Origin of Species.*—Darwin.)

We now have to consider briefly the evolution of a few curious dentitions. This will perhaps be best accomplished by studying the following diagrams, which show the gradations by which the various changes may have been effected. The first represents a sagittal section of the skull of a dog showing a typical carnivorous dentition. The next diagram shows the skull of a common otter, which has a somewhat simplified dentition. We now pass on to the skull of the sea-leopard,

FIG. 18.

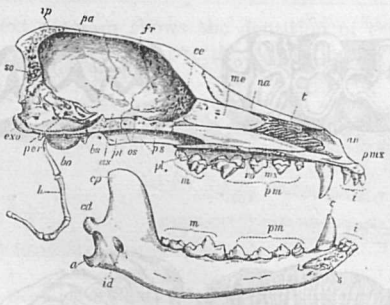


FIG. 19.

FIG. 18.—Skull of dog to show dentition. i Incisors. c Canines. p m Premolars. m Molars. (From Brit. Mus. (Nat. Hist.) Guide Book.)

FIG. 19.—Skull of Common Otter. i Incisors. c Canines. p m Premolars. m. molars. (From Brit. Mus. (Nat. Hist.) Guide Book.)

or leopard-seal, in which the teeth are simpler and better adapted to a piscivorous diet; lastly we have the denti-

FIG. 20.—Skull of Leopard-Seal or Sea-Leopard. i incisors. c Canines. p m premoral. m Molars. (From Brit. Mus. (Nat. Hist.) Guide Book.)

tion of the true seals consisting of simple, conical, almost homodont, monophyodont teeth useful only to catch and

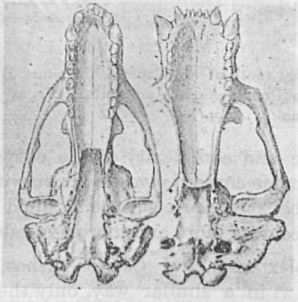


FIG. 21.—Palatal view of cranium and teeth of Brooca's Sea-Bear and the Common Seal. (From Cassell's Nat. Hist.)

hold such slippery prey as fish, upon which they largely feed, but useless for any sort of mastication, each fish being invariably swallowed whole.

A similar reduction in complexity of tooth pattern has taken place in Sirenia. The teeth are also reduced in number, their function being, in part at least, performed by plates of horn.

This kind of reduction and replacement by horny structures has also taken place in whales (*e.g.*, also Chelonia and Aves). Some extinct forms, Squalodon and Zeuglodon, had a heterodont dentition, whilst in the Porpoise and Dolphin the teeth are simple, homodont and monophyodont.

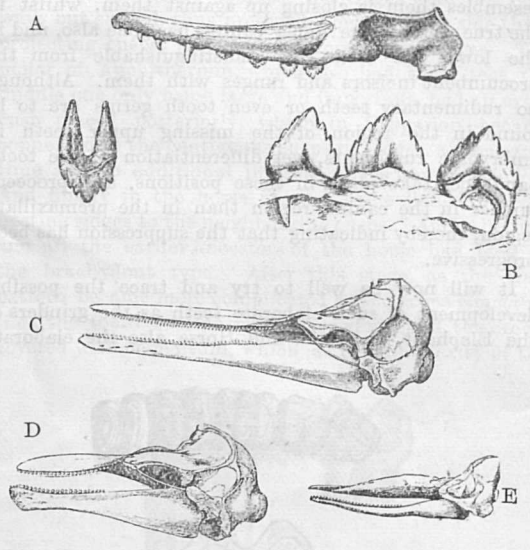


FIG. 22.—Jaws and teeth of—A. Zeuglodon cetoides. B. Squalodon. C. Delphinus delphis. D. Phocœma communis. E. Cachalot—Phyceta Macrocephalus (much reduced). (From Brit. Mus. (Nat. Hist.) Guide Book.)

In the sperm whale the teeth are reduced in number, and besides being deficient in structure are but weakly implanted. This reduction has gone even further in Hyperodon and Mesoplodon, only two, or at most four, teeth remaining in the lower jaw; the edentulous upper jaw, however, is studded over the palate with horny knobs which perform the function of teeth. Finally, the most elaborate and curious arrangement found in baleen whales was arrived at, so as to perform the functions carried out by teeth in other mammals. The descent of these edentulous cetaceans from toothed ancestors is indicated by the presence of rudimentary teeth in fœtal whales. It is also noticeable that those genera, where very great reduction in the complexity and number of the teeth has taken place, are often very aberrant in thin dermal coverings (*e.g.*, whales, edentates, etc.).

Perhaps one of the most curious dentitions familiar to us is that found in the peccora (*i.e.*, sheep and oxen). Gradations may nevertheless be traced from so typical an animal as the pig, which has three chisel-like incisors in each jaw, and tusk-like canines. In the camel only one incisor remains in the upper jaw and this is the corner tooth, the two inner pairs are present in quite young individuals, but are lost early; the canines are

large and pointed, although not tusk-like as in the Suidæ, the lower incisors are somewhat procumbent and the canine very similar to that in the upper jaw. The next step towards the highly specialised dentition of a true ruminent is exemplified by the deer, in which all the upper incisors are gone, but a small canine still remains (not the tusk possessed by a few deer as a secondary sexual weapon, but a small tooth seen in nearly all deer) [*e.g.*, skull over door in Smoking Room G.H.S.C.] ; the lower incisors are procumbent, and the canine which resembles them is closing up against them, whilst in the true peccora the upper canine has gone also, and in the lower the canine is indistinguishable from the procumbent incisors and ranges with them. Although no rudimentary teeth or even tooth germs are to be found in the region of the missing upper teeth in embryonic ruminents, yet differentiation of the tooth band does take place in these positions, and proceeds further in the canine region than in the premaxillary region, thereby indicating that the suppression has been progressive.

It will now be well to try and trace the possible development of such elaborate teeth as the grinders of the Elephant, Capybara and Horse, also the elaborate

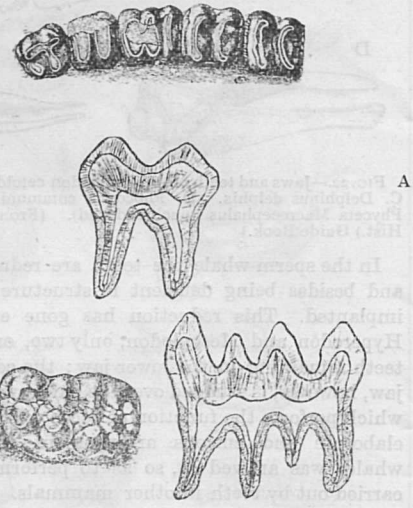


FIG. 23.—Masticating surface and vertical longitudinal section of molar of—A Dinotherium Giganteum and B Mastodon Longirostris. (From Brit. Mus. (Nat. Hist.) Guide Book.)

poison fang, and hinged superior maxilla of viperine snakes. Here again, perhaps, a few diagrams will help to make the stages clearer. Starting from the molar of Dinotherium, which somewhat resembled that of tapir, we pass from the molar of Mastodon in which the number of ridges and the depth of the tooth were increased (varying with different species) to that of Elephas Planifrons, in which the ridges were more numerous and the cusps deeper. Finally the ridges of the molar of the African Elephant lead us through the

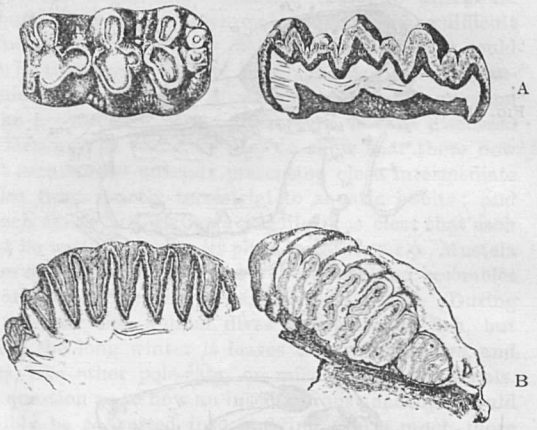


FIG. 24.—Masticating surface and vertical longitudinal section of molars of—A Mastodon angustideus and B Elephas planifrons.

tooth pattern of the Indian to that of the Mammoth, which is the most complicated form of all.

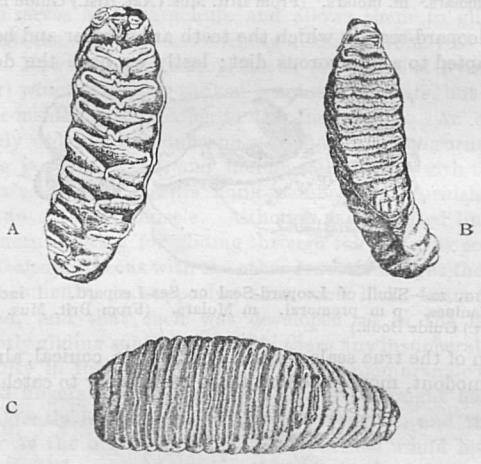


FIG. 25.—Molar teeth of—A Elephas Africanus, B Elephas Indicus and C Elephas Primigenius (Mammoth . (From Brit. Mus. (Nat. Hist.) Guide Book.)

As the size and complexity of the cusps increased so the tooth became covered over its crown with cementum, the furrows between the cusps being filled in solidly and the tooth becoming more and more hypsodont.

The complex molar of Capybara has undoubtedly been arrived at in a similar way, only the inflexions of the surface seem to have dipped in from the sides of the tooth rather than from its grinding surface.

These teeth are of persistent growth, *i.e.*, they have become so very hypsodont that they never got so far as the formation of definite roots.

The next diagram shows the dentition of the horse, whose very complex molar teeth may be traced by easy

FIG. 26.—Dentition of Equus caballus (horse) permanent and milk. (After Owen.)

gradations from the simplest forms. As has been pointed out by W. B. Scott and also Marret Tims, it is easy to understand how a simple haplodont tooth with a cingulum could develop into a quadricuspid tooth by the addition of cusps to the posterior and internal parts of the crown. Such a quadricuspid tooth would not be far removed in shape from that of Euprotogonia, an ancestor of the horse. This and the following figure are perfectly diagramatic representations of the unworn grinding surfaces of various molar teeth. The grey circles indicate the position of cusps, whilst ridges are shown as one, two or three straight or wavy lines, as the case may be, depending on their size and direction.

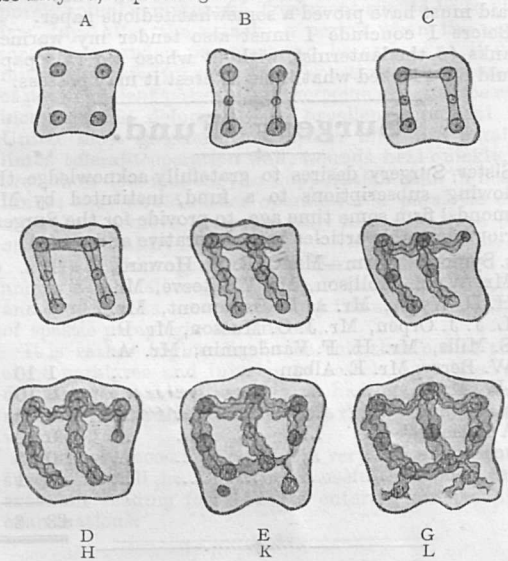


FIG. 27.—Masticating surfaces of molar teeth of—A Typical quadricuspid molar. B Euprotogonia. C Tapir. D Hyracotherium. E Rhinoceros. G Paleotherium. H Anchitherium. K Hipparion. L Equus caballus. (C.D.W.)

Euprotogonia (one of Condylarthra) was a small, slender, long-limbed animal with a large heavy tail. It was semi-plantigrade, and although it had five toes, it walked on the three middle ones the third toe being pre-eminent, and was therefore perrisodactyl. Each digit was furnished with a horny sheath intermediate between a nail and a hoof. This animal was therefore a very primitive and generalised ungulate form. Slightly more specialised is the molar of Tapir, with which we are all familiar. Hyracotherium, whose molar is next figured, was a small animal about three feet long, having four toes on each fore-limb and three on each hind-limb, but still the third toe being pre-eminent the animal was perrisodactyl. The molar teeth of Rhinoceros are very like the last except that the ridges are wavy instead of being straight. In Paleotherium, an animal intermediate in size between the sheep and horse, with three toes on each foot and large canines, the ridges were not only wavy but curved, thus presenting on the outer side three projecting cusps, joined by two crescentic ridges. The molar of Anchitherium, which also had three toes, the middle one only being large and important, had an extra cusp placed posteriorly, which in Hipparion became connected to the contiguous cusps by ridges, at the same time as two additional internal cusps were developed. And finally in the horse these became linked by connecting ridges to the neighbouring cusps. Anchitherium and all the earlier ancestors of the horse had teeth of the brachydont type. After this stage, as the cusp pattern became more complicated so the cusps elongated (*i.e.*, the tooth became more hypsodont) and the crown covered with cementum, which, as the complexity of the

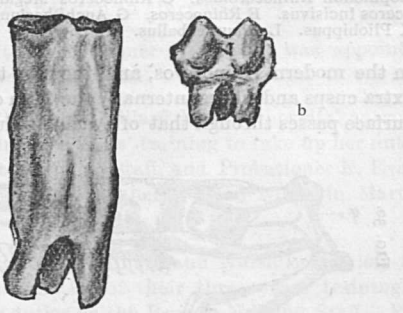


FIG. 28.—Molar teeth of—a Horse (hypsodont) and b Anchitherium (brachydont). (Adapted from Tims.)

cusp surface became greater, tended more and more to solidly fill up all the interstices between the cusps and ridges; so rendering the grinding surface rougher and more suited to the harsher dryer food upon which the animals subsist.

As regards the horse's lower molar, I hope the next diagram may be almost self-explanatory. The first sketch represents the lower molar of Tapir, probably evolved like the upper molar from a simple type. The next link in the chain of changes is found in the lower molar of Lophiodon Rhinoceroides. Lophiodon was about the size of a Tapir, and as its name implies was intermediate in many ways between Tapir and Rhinoceros. Its teeth, as we have seen, were also intermediate in form, although the anterior premolars were simpler than those of the modern Tapir or Rhinoceros. The further stages of development are to be traced in certain extinct species of Rhinoceros. In R. Megarhinus of the lower Pliocene the ridges were curved, but still transverse. This curvature had proceeded to such an extent in the molars of

R. Incisivus that the ridges came to be almost directly in front of each other presenting their convexities outwards. This arrangement became even more pronounced

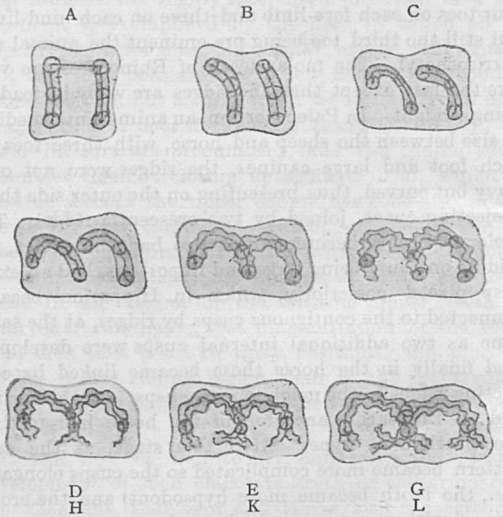
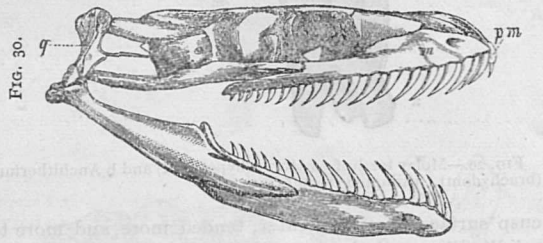


Fig. 29.—Masticating surfaces of molar teeth of—A Tapir. B Lophiodon Rhinoceroides. C Rhinoceros Megarhinus. D Rhinoceros Incisivus. E Rhinoceros. G Anchitherium. H Hipparion. K Pliohippus. L Equus caballus. (C. D. W.)

in the modern Rhinoceros, and then by the addition of extra cusps and ridges internally the form of the grinding surface passes through that of Anchitherium, Hipparion and Pliohippus to the more complex arrangement seen in the horse.



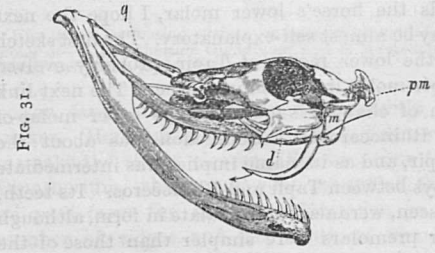


Fig.—30.—Skull of Pithon. m Maxilla. pm Premaxilla. q Quadrate. (From Brit. Mus. (Nat. Hist.) Guide Book.)

Fig 31.—Skull of Viperine snake (Bitis nasicornis). d Poison fangs (the functional one with bristle through poison canal). (From Brit. Mus. (Nat. Hist.) Guide Book.)

It is with comparative ease that the steps in the evolution of the huge canaliculated poison-fang of viperine snakes can be traced. The pythons have quite an ordinary reptilia dentition. In the Proteroglypha one or more of the anterior teeth on the superior maxilla are grooved anteriorly; this reaches its greatest development in the cobra, in which the fang is so far differentiated as to be canaliculated, halthoug the edges of the tube are not thoroughly fused; the tooth, so to speak, becoming folded round upon itself so as to form a tube. The cobra also exhibits a certain amount of mobility of its superior maxilla (about an angle of 45°) which foreshadows the more perfectly specialised poison apparatus of the vipers.

I feel painfully conscious of the fact that I have dealt but inadequately with this subject, and yet have taken up a great deal of your time, for which the discussion of this fascinating subject will, I trust, fully make amends.

I hope you will excuse any mistakes which may have crept in, although all the facts have been verified to the best of my ability.

I also wish to point out that the stages of evolution suggested in this paper do not pretend to be an account of the actual line of descent (for that, from the nature of things, must be for ever hidden from us) but only a possible and even probable explanation of some of the curious and complex forms which we see around us.

I must thank you very sincerely for the kind and close attention with which you have followed what I am afraid must have proved a somewhat tedious paper.

Before I conclude I must also tender my warmest thanks to the lanternist, without whose aid this paper would have lacked what little interest it may possess.

Surgery Fund.

Sister Surgery desires to gratefully acknowledge the following subscriptions to a fund, instituted by Mr. Symonds' firm some time ago, to provide for the Surgery various desirable articles both decorative and useful.

	£	s.	d.
Mr. Symonds' Firm—Mr. C. R. H. Howard, Mr. W. M. Mollison, Mr. W. Reeve, Mr. H. D. Wyatt, Mr. A. R. Beaumont, Mr. L. J. J. Orpen, Mr. J. O. Musson, Mr. P. S. Mills, Mr. H. F. Vandermin, Mr. A. W. Berry, Mr. E. Alban	1	10	0
F. W. M. P.	0	10	0
Mrs. Palmer	0	10	0
"A Patient"	0	10	6
Two Nurses	0	5	0
Miss Rendle	0	1	0
	£3	6	6

Chapel Fund.

Additional Contributions to Decoration Account.

	£	s.	d.
R. A. Hankey, Esq.	100	0	0
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Sir Frederick Wigan, Bart.	5	0	0
E. H. Lushington, Esq.	3	3	0
Rt. Hon. Lord Biddulph	2	2	0

Reviews.

The price of books submitted for review should in every case be stated.

The Surgery of Paralyses. By A. H. Tubby and Robert Jones, pp. 311. (Macmillan & Co.) 10s. net.

We very much regret that, through inadvertence, this work has not yet been reviewed in our columns, and may preface our remarks by saying that it maintains the high standard of excellence with which we always associate Mr. Tubby's name. He is a scientific surgeon, and practises no operation which has not been thoroughly thought out, as witness his important observations on Regeneration of Tendons, which he published in the Guy's Reports. In the work now before us the authors especially recommend the practice of Muscle Grafting and Tendon Transplanting, as means of treatment in various deformities, generally giving better results than the older tenotomies. A chapter is devoted to this form of treatment for the lower extremities, and elaborate descriptions of the technique of the various operations.

The whole book is evidently the result of personal experience, and as such is most convincing, pleasantly written, and capitally illustrated by good diagrams and some photographs.

There is a very good chapter on the Etiology and Pathology of Infantile Paralysis, in which all the evidence of the infective nature of the disease is collected, the various epidemics are described, in which we are told there is a tendency towards cerebro-spinal rather than purely spinal symptoms. Treatment should be started a few days after the attack—a period when the case is rarely seen, and a prognosis can be arrived at, if deformity has existed for some time, by estimating the amount of power patient possesses to overcome a resistance which increases the deformity—an excellent practical test. Unlike most surgeons, the authors find that paralysed limbs tolerate operation well, wounds heal quickly, and even show less tendency to suppuration than in healthy limbs; they would rather operate for a paralytic deformity than remove a foreign body from the knee of an otherwise healthy limb.

A plastic skin operation is preferred for fixing at right angles a flail elbow-joint, rather than an arthrodesis, and good results are obtained by the surgical treatment of spastic paraplegia of children.

It is rather frightening to be told that out of thirty-eight paralyses and injuries to vessels associated with dislocated shoulder, twenty-nine had been produced by reduction with the heel in the axilla—surely a belated warning!

As an advanced text-book on a very difficult branch of surgery, it will be found most useful and will provide excellent reading for students entering for the higher examinations.

From the Gazette's Special Pathologist.

NOTICES.

J. R. A., CHADWELL HEATH.—This specimen of sputum was purulent, but tubercle bacilli could not be found in it.

J. R. A., CHADWELL HEATH.—A smear preparation made direct from this swab showed the presence of Klebs Loffler bacilli.

H. R. M., HASTINGS.—This sputum contained mucopus, but no tubercle bacilli were found.

C. T. B. M., WITHAM.—*Reaction* acid, *Sp. gr.* 1011. *Albumen* a large amount, *Blood* vide infra, *Sugar* absent.

Microscopical examination of the centrifugalised deposit. The deposit contains a large amount of epithelium of the renal tubular and renal pelvic types, together with granular hyaline and epithelial tube casts, and scattered red blood discs. There are also many bacteria associated with the decomposition of the urine.

Pus is absent and no crystals are seen.

PATHOLOGIST.

Nursing News.

MATRON'S OFFICE.

On June 2nd, Nurse Plant was transferred from Bright ward to the Surgery, and Nurse Denton was transferred from the Surgery to Miriam ward.

On June 25th, Nurse Grigor left the hospital on completion of her three years' training, and Probationer Barker was appointed to succeed her as Head Nurse in Out-patients.

On July 2nd, Probationer Aitken was appointed to succeed Nurse Mackenzie in Astley Cooper ward.

On July 5th, Probationer Cannell was appointed to succeed Nurse Anderton in Mary ward.

On July 7th, Probationer Bromwich was appointed Head Nurse in Bright ward.

On July 8th, Nurse Millard left the hospital on completion of her three years' training to take up her duties on the Private Nursing Staff, and Probationer F. Evans was appointed to succeed her as Head Nurse in Martha ward.

On July 9th, Nurse Millard and Nurse Lokier left the hospital on completion of their three years' training to take up their duties on the Private Nursing Staff, Probationer G. Harvey was appointed to succeed Nurse Lokier in Charity ward, and Probationer Danson was appointed to succeed Nurse J. Thomas in Dorcas ward.

On July 12th, Nurse Morley left the hospital on completion of her three years' training.

On July 20th, Nurse DuBoulay left the hospital on completion of her three years' training.

On July 21st, Miss Traill, Sister Esther, left the hospital to take up her duties as Matron at the County Hospital, Guildford.

Students' Chapel Choir.

At a general meeting held on Wednesday, July 20th, it was decided that a Vacation should be held during the months of August and September. Due notice will be given of the resumption at the commencement of the new session in October. R. FELTON, Hon. Sec.

Sport.

Cricket.

GUY'S v. WISETON.

This match was played at Wiseton on 14th and 15th July, Guy's winning easily by nine wickets.

Wiseton batted first on a perfect wicket, and made 259, thanks to H. O. Peacock who made 101. Davies bowled well, but Wyatt was rather expensive. Bookless and Wyatt opened our innings, but with only 7 runs scored, the former was bowled. Willan and Wyatt took the score to 118. When both Willan and Langdale were out, but with Archer in, Wyatt hit the bowling all over the field and soon reached his century; his brilliant innings was ended by a catch in the slips, the total being 232, of which number he claimed 139. Archer was out in a similar manner in the next over, having played a sound innings for one hour and three-quarters. Morres and Simms stayed together till time, when the score was 250 for five.

The game started punctually on the second day, and we totalled 330, Simms playing very well for 67. Wiseton collapsed in their second innings against the bowling of Bartlett and Davies, Farmer alone making any runs. Bartlett took five wickets for 50. We were left with 61 to win, which number Langdale and Bookless soon hit off. The team was splendidly entertained by Capt. Laycock. Scores:—

WISETON.

	1st innings.		2nd innings.	
Rev. E. E. Farmer, c Bartlett, b Wyatt	17	c Simms, b Bowle	47
W. Garrard, b Davies	24	run out	17
Hon. E. Egerton, c Wyatt, b Bowle	19	c Langdale, b Bartlett	0
L. A. Weigall, b Wyatt	29	b Davies	12
N. Fergusson, c Bartlett, b Bowle	12	b Bartlett	9
Capt. H. O. Peacock, c Archer, b Bartlett	101	c Wells, b Bartlett	4
H. C. Farmer, c Wells, b Davies	29	b Bartlett	2
E. Batty, b Wyatt	9	c Wells, b Bartlett	4
F. Guyler, c Wyatt, b Davies	6	c Langdale, b Davies	6
C. Peck, run out	5	run out	18
— Ramsbottom, not out	5	not out	2
Extras	3	Extras	10
Total	259	Total	131

GUY'S.

J. S. Bookless, b Ramsbottom	6	c & b Ramsbottom	16
H. D. Wyatt, c E. E. Farmer, b Guyler	139		
R. Willans, b Peck	46		
H. M. Langdale, c Fergusson, b Peck	0	not out	40
H. Archer, c E. E. Farmer, b Guyler	38		
F. Morres, c Fergusson, b Ramsbottom	12	not out	5
H. Simms, c & b Peck	67		
S. M. Wells, b Guyler	0		
S. C. Bowle, b Guyler	8		
L. G. Davies, not out	5		
G. N. Bartlett, run out	2		
Extras	7	Extras	2
Total	330	Total (1 wkt.)	63

Pass List.

University of London, July, 1904.

M.D. EXAMINATION.

BRANCH I.—MEDICINE.—H. Barber, N. N. A. Houghton, J. F. Northcott.

BRANCH IV.—MIDWIFERY AND DISEASES OF WOMEN.—G. S. Robertson.

BRANCH V.—STATE MEDICINE.—Myer Coplans.

M.S. EXAMINATION.

W. H. Bowen.

Appointments.

Civil.

COPLANS, MYER, M.D. Lond., D.P.H. Camb., has been appointed Medical Inspector of Schools to the Gloucestershire County Council.

SPON, H. J., M.R.C.S. Eng., L.R.C.P., D.P.H. Camb., has been appointed Surgeon to the Surrey Dispensary, *vice* J. Dixon, J.P., M.D., resigned.

TURNER, F. DOUGLAS, M.B. Lond., M.R.C.S., L.R.C.P., has been appointed Medical Officer to the Post Office, and Medical Examiner to the Board of Education at Huddersfield.

Naval and Military.

Surgeon C. R. NICHOLSON, R.N., has been appointed to the Royal Marine Division, Portsmouth.

Captain A. W. SHEEN, M.D., is appointed to command the Welsh Bearer Company, Royal Army Medical Corps (Volunteers).

Papers by Guy's Men.

The Method of closing an Abdominal Wound. By John D. Malcolm, M.B., F.R.C.S. Edin.—*The Lancet*, 23rd July.

Case of Wilful Introduction of Foreign Bodies into the Œsophagus: Death. By J. H. Targett, M.S. Lond., F.R.C.S. Eng.—*Ibid.*

On Vincent's Angina. By H. W. Bruce, M.D., B.S. Lond., F.R.C.S. Eng.—*Ibid.*, July 16th.

A Fatal Case of Cyanosis with Enlarged Spleen. By Theodore Fisher, M.D. Lond., M.R.C.P.—*British Medical Journal*, July 23rd.

Birth.

WAY.—On July 9th, at Kenilworth Lodge, Southsea, the wife of Montague Way, M.R.C.S. Eng., L.R.C.P. Lond., of a son.

Marriage.

NICHOLSON—RAPER.—On July 9th, at the parish church of Battle, Sussex, by the Very Rev. the Dean, assisted by the Rev. H. von Glehn, Surgeon Charles Rowley Nicholson, R.N., eldest son of Emilius Rowley Nicholson, M.D., to Christine Mary Francis, eldest daughter of W. Augustus Raper, of Battle.

Death.

MARSHALL.—On July 13th, at Church House, Mitcham, Edward Marshall, M.R.C.S. Eng., L.S.A., aged 78.

R. E.—ED.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 425.] AUGUST 27, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	333–335
Actino-Therapeutics. Two Lectures by Mr. Gerald Sichel	336–344
A Case of Remarkable Vitality	345–346
Change of Address	346
Reviews	347
Nursing News	347
In Lighter Vein	348
Correspondence	348
Efforts	349
List of Names for the Proposed Chapel Memorial	349
Pass List	349
From the Gazette's Special Pathologist ...	350
Sport	351–325
Appointments	352

Passim.

IF for the ordinary man the long vacation is a weary and colourless period, words fail us to describe the plight of the starving chronicler of events. The vigilance of the Japanese censor has furnished us with abundant proof that a few emaciated facts, when skilfully handled, can go an extraordinarily long way towards filling the columns of the daily papers—witness the efforts of those mysterious beings the special military correspondents. With the doings of these notorious exemplars as an encouragement, we return once more to press, albeit with a somewhat heavy heart. There can be no doubt about it that the Hospital is not a place wherein one would choose to spend the vacation. Stern necessity alone keeps those unfortunates who remain from flying unto Alp and moor, broad and links, and, in the opinion of this small but devoted band, a poet might well be chartered to sing of nothing but their nobility and self-sacrifice.

PERHAPS the lot of those who endeavour to read is the hardest of all. There is positively nowhere for these to lay their heads. The Library is shut for the best of all possible reasons, namely, that it has always been shut in August for as long as anyone can remember. The Wax Museum, whither a few stricken souls repair to glean a few facts against the evil day, is positively given over to the Hospital workman. A couple of these latter, for reasons of their own which it would be profitless to discuss, have adopted the pleasing habit of emerging from a trap-door immediately beneath one specimen of the abdomen (we can see no special reason for their choosing this specimen, unless it be that there is no trap-door elsewhere). They perform this feat with a suddenness which is alarming, and their loud voiced comments on the facial expression of certain of the wax faces are as annoying as they are ungrammatical; for several minutes these useless intruders stand and breathe deeply and audibly as though they had completed some great task—they have never done a stroke of real work in their lives, however, and the exasperated listener is not deceived by this ruse—and then with the resigned appearance of a man who is going to a minimum of work, they make an ungraceful and noisy exit through the same trap-door. They have probably gone to play at salvage corps and one is glad to get of rid them.

IF, disgusted by the antics of these licensed nuisances and mindful of earlier afternoons spent in the pickle-room, our student should go over to the latter place in search of specimens and quiet, he finds the dissections have been so assiduously picked at and his imagination will be called upon to fill in so much, that he must needs confine himself to the diagrams in the books, and they are cold comfort. Later even this compromise becomes impracticable, owing to the shouting and tramping of more workmen immediately outside the pickle-room door. Maddened by this persistent thwarting of his conscientious efforts, he tries the Park as a last resource. Human nature asserts itself here and he finds the enemy in his own heart also, to say nothing of in the Nurses' Home. It is here that life begins to assume a more roseate hue, and he thinks of the Squash Court only to remember that the workmen are in possession of its ruin, and that the plans of the new court are still on the laps of the gods. Still there remains the Swimming Bath; why had he not thought of it before? He abandons books and hurries expectantly in the direction of the bath, where, having first carefully divested himself of his boots (for he is an unselfish person, and does not like to trample mud into the floor), he finds the dry tiles of the floor of the bath staring him out of countenance—it has been

proposed, says a smiling engineer, to erect a spring-board, and the bath has been emptied for that purpose.

THIS proposed spring-board will be an admirable addition to the swimming bath, and it is to be hoped that its erection will soon be an accomplished fact. At present there seems to be some doubt as to where would be the best place for it. The suggestion that it should be placed transversely at the end from which men (and presumably nurses also) usually dive, is obviously not a good one—the board would not be long enough to provide sufficient spring, and would be but a small improvement on the present state of things. If it were made to project from the arch just to the right of the first flight of steps into the water, in such a way that it pointed out from the recess over the deeper water in the direction of the deep end, it would be possible to get a fairly good running dive. In any case the space is somewhat limited, but this situation seems to commend itself to reason. This may not be an unfitting opportunity to complain that the water in the bath is too often more than tepid, it is positively warm, and though exercise can still be got, even in lukewarm water, the results are not nearly so refreshing as they would be were the water several degrees colder. This state of affairs is all the more noticeable in the warm weather, and if it could be altered it would make the bath a much more attractive place than it is at present.

IN making these comments we are only expressing the opinions of the men who frequent the bath; but these, while fully realising that the bath belongs essentially to the Nurses' Home, feel sure that the aquatic habits of us all are pretty much the same.

THE strides that have been made in the last six weeks towards the completion of the Actino-Therapeutic Department are truly amazing. Though not in any sense of the word finished from the point of view of furniture, scientific or otherwise, the department is nevertheless in fairly good working order, and Guy's is thus enabled to do more valuable work in this direction than it has been possible to undertake hitherto. We are told on the best authority, and certainly should be unable to deny it were the authority less excellent, that the apparatus at present in use comprises a large Finsen lamp, a Finsen-Reyn lamp, a Lortet-Jenoud lamp, which is giving very good results in the treatment of lupus, X-ray apparatus with lead glass shield (to prevent dermatitis), Leslie Miller iron spark lamp, high frequency apparatus, muscle testing apparatus, vibratory massage apparatus, large Wimshurst machine (in separate room), and an electric bath (in separate room). Doubtless there will be many who would wish to be further acquainted with these various appliances, the bare names of which compel awe, wonder and bated breath, and there seems some possibility that opportunities will be afforded men in the near future for acquiring at least a bowing acquaintance with the ways and means of the various forms of light cure.

MANY old Guy's men will be interested to read of the marriage of a son of Dr. George Turner with the daughter of the late Dr. Mahomed, Assistant Physician to this Hospital from 1882–1884, whose early death deprived Guy's of the services of one of its most promising sons. Dr. Turner, who was the predecessor of Dr. Pakes in the Public Health department, is now Medical Officer of Health to the Transvaal, and the *Pretoria News* of July 30th contained a caricature of him presenting the Rand with a gallows "which would," he had previously declared in the Legislative Council during the consideration of estimates, "save the travelling expenses of many criminals sent from Johannesburg to Pretoria for execution." The caricature is, we feel sure, a most infamous libel on Dr. Turner, who would doubtless be the first to present himself for capital punishment did his personal appearance in any way resemble the creature of the artist's fancy.

THE *British Medical Journal*, for which it is impossible for the light-minded to have too much respect, has lately been interesting itself in the philosophy of clothes. "Sartor Resartus" would seem to be rankling in the mind of the writer of the paragraph in question, but it is obviously impossible for the members of a most realistic profession to take even as their sartorial guide that Apostle of the Ideal—Carlyle. The *B.M.J.* seems to advocate a marked uniformity in the dress of our profession—but surely there would be precious little philosophy in such a proceeding—at least, very little of the Carlylean kind, which had its root essentially in the idea that character should evince itself in clothing. The writer goes on to dilate on the "hierophantic" nature of the medical profession and speaks of the older generation of French doctors "who, habited in long gowns rode through the streets on mules—animals of an almost sacred character as they were especially used by

churchmen and doctors!" Why this connection between a skilled and an unskilled profession? And why, because the older generation of French doctors were willing to incongruously associate themselves with the clergy, and to parade the streets on mere mules, should the modern members of the medical profession dress themselves as other than ordinary English gentlemen. Why should a medical man want to label himself in company with bishops and clergy, butchers, bakers and candlestick makers? There are reasons for the scarlet coat of the soldier; there may be reasons why the judge and the barristers should assume the wigs and robes of the law; there is no reason why non-celibate clergy should assume their inky suits; and there can be no reason why a medical man should wear distinctive clothing, unless it be as a miserable advertisement.

"The field," says the *B.M.J.*, "is open to artistic persons with a talent for the invention of dainty devices and appropriate schemes of colour"; and we doubt if the dealer in artistic advertisement was ever cajoled in more winning words.

We should like to call special attention to the list, published in another column, of the names which have been proposed, up to the present, as worthy to be inscribed on the Memorial soon to be placed in the Chapel. The list goes back as far as 1880, but it is quite possible that there are names that have been accidentally omitted. Should this be the case, will any reader of the Gazette who may mark the omission kindly point out the same to the Chaplain by letter? We may add that the list is meant to comprise all those who died while actually employed in the medical or nursing work of the Hospital. The Chaplain is particularly anxious that letters should not be addressed to him by name, but should simply be addressed to the Chaplain, Guy's Hospital.

We have received a most interesting letter from Mr. A. B. O'Brien, giving us an account of a dinner given by old Guy's men to the Guy's contingent of the Anglo-Australian Football Team during their stay in Sydney. Mr. O'Brien says: "Of course it was no surprise to us that recent men like John Harris and C. R. Hodgson should look us up during our stay here, but that men who entered as far back as '69, and who now are leading men in Australia in their particular branches of their profession, viz., Dr. Thomas Evans and Dr. Foreman, should not only spare the time to meet us, but also prepare us an excellent dinner and devote a whole evening to our entertainment, was an honour which all of us greatly appreciated." He goes on to say that, although they have been fêted and feasted everywhere, that evening with the old Guy's men was by far the most pleasant they have spent.

To quote further from the same letter:—"The dinner was organised by Drs. J. M. Gill and John Harris, and Dr. Thomas Evans presided. Nine old Guy's men turned up to welcome us, namely, Drs. Thomas Evans, J. Foreman, P. M. Wood, Fred. W. Hall, Sigismund Brown, George S. Miles, J. M. Gill, John Harris and C. R. Hodgson. Dr. Ashburton Thompson sent a message of regret at his absence. The above names will certainly recall to members of the Staff and old Guy's men some of the friends of their student days. As guests were our five representatives — Trail, Morgan, McEvedy, Saunders and O'Brien, while S. W. Crowther of Westminster Hospital and D. R. Bedell Sivright, captain of our team, were also present. The table was decorated with the Guy's colours. Drs. Evans and Foreman in recalling many incidents of their student life spoke of the old Guy's of their time. In our turn we were able to tell them something of the present state of affairs, and it was quite pathetic to see how the older men inquired after the old people and places. . . . All of us are well and keeping up, if not improving, our reputations in the field. David Trail keeps a fatherly eye on us all, and, in fact, has endeared himself to all the team."

We are sure that all Guy's men will read of this union of past and present with the deepest interest, and not a few in remote corners of the earth will wish that they could have been present also at the dinner, and could have got once more into a Guy's atmosphere which is like unto no other, and which most of us hope to remember—well, as long as we remember anything.

The Physical Society is to be congratulated on having secured Professor Macalister to deliver the opening address on October 8th of the coming Session. There should be an exceptionally full meeting on this account, and we note with satisfaction that the Smoking Room has been chosen in preference to the Physiological Theatre. The subject of the address is not known as yet, but we hope to announce it in our next issue.

Actino-Therapeutics.

TWO LECTURES BY MR. GERALD SICHEL.
March 12th and May 30th, 1904.

I.

GENTLEMEN,—I do not think I can do better than begin this lecture by drawing a rough diagram of the solar spectrum, and indicating the various kinds of rays which interest us in connection with the subject of actino-therapeutics. (Fig. 1.) On either side of this spectrum there

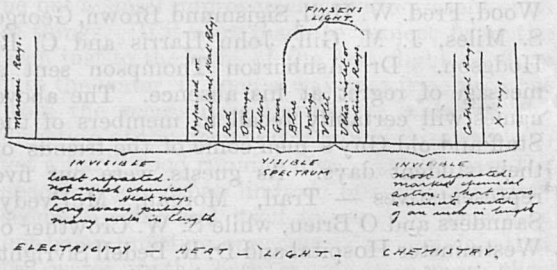


Fig. 1.

are invisible rays; a long way below the red rays you come to the Marconi rays, and next to the spectrum you have the infra-red rays. Beyond the violet end there are the ultra-violet rays, and a long way beyond these again the X-rays, with next to them (nearer to the spectrum) the Kathodal rays. So we have electricity, heat, light, and chemistry connected, going from left to right. The Marconi rays are very long ones indeed, but on the other side of the spectrum the waves are only a minute fraction of an inch long. At the violet end of the spectrum there are the Finsen rays.

There are two other preliminaries which it will be necessary to talk about. One is *refraction*, and the other *polarization*. If a ray of light be allowed to pass through a prism and then on to a screen, it is, by refraction, broken up into its seven component parts, the red rays being the least and the violet the most *refracted* or bent (Fig. 2). As to polarization, it is

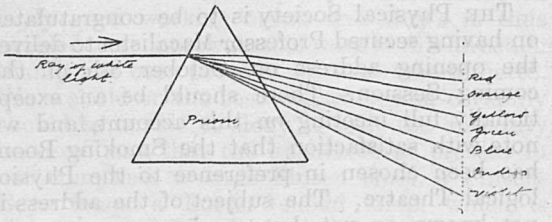


Fig. 2.

assumed that these rays may travel either by vertical or transverse waves.

You can easily imagine that if you have a grid consisting of vertical bars it will allow one set of rays to pass through (the vertical), but not those at right angles (the transverse); but if you split your grid and arrange the bars at right angles both sets of waves will be stopped. The rays are then said to be polarised, and tourmaline is a body which acts thus in polarising light (Fig. 3).

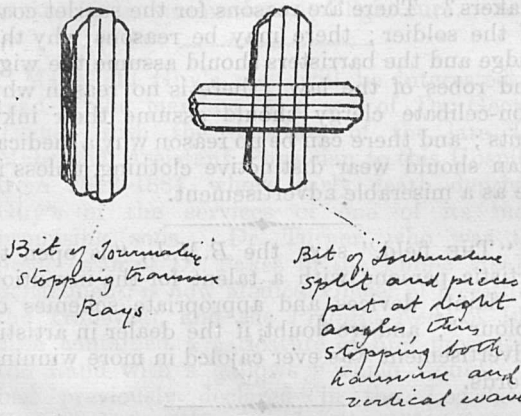


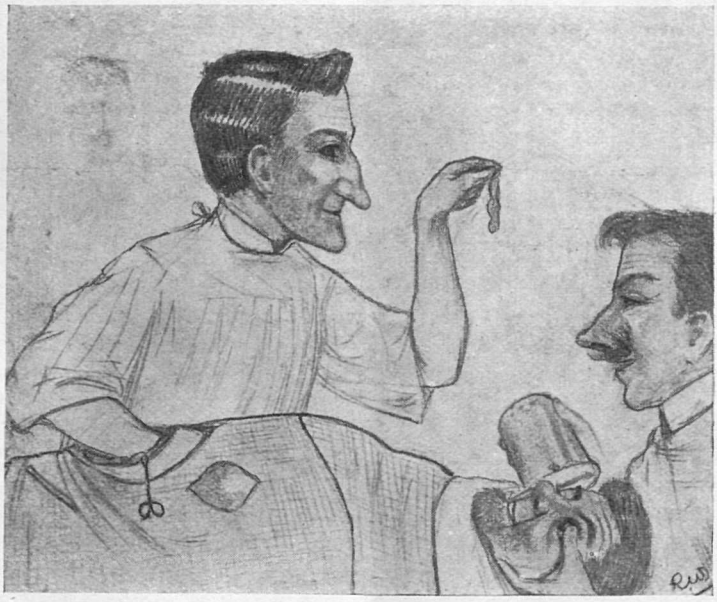
Fig. 3.

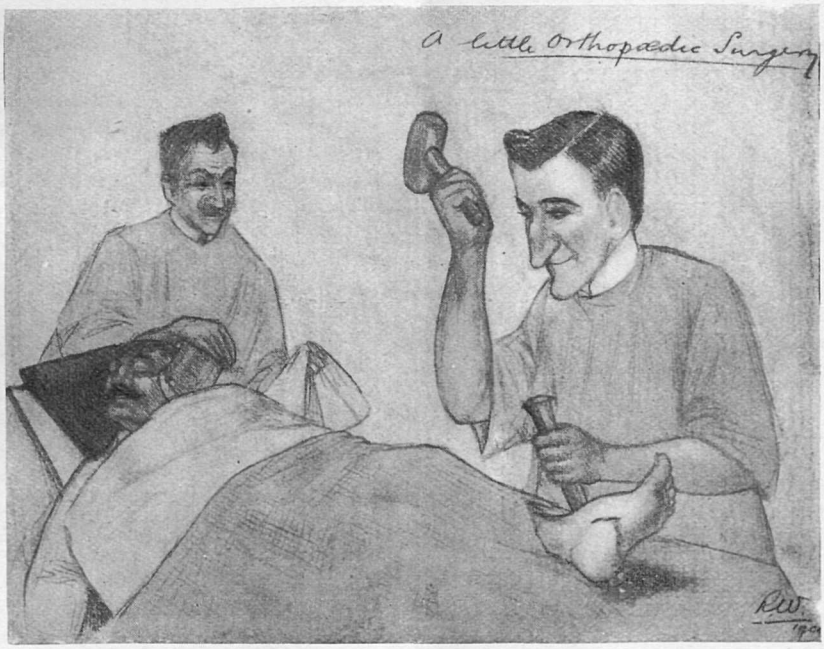
With regard to the rays themselves, there are various things which you must remember. The most important from an actino-therapeutic point of view are the *X-rays*, *Finsen light rays*, and *the emanations of radium*. The most important points about X-RAYS are:—

1. That they act on photographic plates through apparently opaque substances:
2. They are able to excite fluorescence in various bodies, of which the only one you need remember is platino-cyanide of barium.
   You should remember this particular substance because the ordinary fluorescent screen is made of it.
3. They cannot be deflected by a magnet.
4. They can discharge electrified bodies.
5. They probably are not bactericidal in action at all.

FINSEN LIGHT is—

1. Strongly actinic, and that is its most marked feature; it has strong chemical action; and
2. Can discharge bodies negatively electrified. You can easily demonstrate this by means of the electroscope.
3. It is bactericidal, and





The Operations of Surgery—(two of 'em.)

4. Lastly, it is important to remember that glass is opaque to it, but ice, rock-salt, and quartz are transparent to it. It is strongly actinic and strongly chemical.

It is bactericidal, but it is important to remember that this action is stopped by a very thin film of organic matter, such as gelatine. Therefore its action in lupus is probably not a bactericidal one, but depends upon actinic action, and its beneficial results are due to its causing a reaction in the normal elements of the skin. The bactericidal rays have been very accurately localised in the centre of the ultra-violet rays by Barnard and Morgan.

It is important to remember that glass is opaque to these rays, so you must not have a lamp with a glass lens; it must be of ice, rock-salt or quartz. Quartz is not so transparent to these rays as the other two substances, but perhaps it is the most practicable one to use.

Radium emits three kinds of rays :—

1. The Alpha rays, which are either composed of, caused by, or accompanied with, the letting loose of a gaseous emanation. This gas was found out by Sir William Ramsay, and Mr. Soddy, to eventually resolve itself into helium.
2. The Beta rays are similar to, and very likely identical with, Kathodal rays.
3. The Gamma rays are very likely identical with X-rays.

The first rays have been estimated by Professor Rutherford as constituting 99 per cent. of all the rays of radium, and they are stopped by glass. The gases which are thrown off apparently cause no practical reduction in the bulk of the radium. And lastly (a point which is of interest in physics) radium constantly preserves a temperature 3° to 5° above surrounding bodies. Another useful thing to remember is this : I told you that glass absorbed the ultra-violet rays. A practical point to remember is, that water absorbs the infra-red rays at the other end of the spectrum, and therefore is used for filtering off the infra-red rays when you want to eliminate the effects of heat for the light treatment.

The facts which I have written up on the board are absolutely trustworthy. When I heard it was likely that I should have to give this lecture I wrote to Sir William Ramsay and to Dr. Dawson Turner, of Edinburgh, and they were both kind enough to answer my queries, so you may rest comfortably assured that if I have told you little it is at all events reliable.

For the production of X-rays the essentials are that—

1. The electricity shall be of high potential, and
2. That there be used a vacuum tube of high exhaustion.

Some may have forgotten what "potential" means, so I will write up on the board these three terms. When you are talking about electricity you must know what you mean by—

1. "*Current*," or "ampèreage";
2. "*Potential*," or "electro-motive force" (sometimes written E.M.F.), or "voltage."
3. The "*resistance*" which is encountered by the electric current when going through a wire or other conductor.

I think these terms are best explained by the analogy of water from a cistern running through a pipe. If you have a cistern high up, and a very narrow pipe below it, leading to a tap, the water has got a "good head," as it is called, and although you only get a small stream, it has got great force, therefore the "potential" is high. But as you have a narrow pipe the "resistance" also is great (Fig. 4). We will now depict the opposite condition of things: a cistern low down with a broad pipe leading from

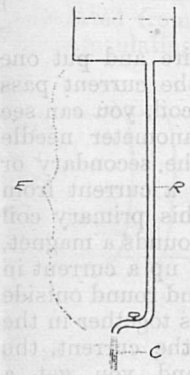


Fig. 4.

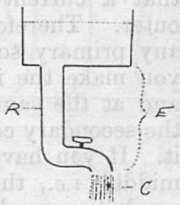


Fig. 5.

it, and a tap. In the second case the electro-motive force is small, but the current is great (Fig. 5). The first is the sort of electricity we want for X-rays. You must remember the relationship which these three important factors bear to each other. It is represented by the formula $C = \frac{E}{R}$; and that is known as Ohm's law. In *memoria technica* form you can put it

: that is $C = \frac{E}{R}$, $E = C \times R$, $R = \frac{E}{C}$.

The best way to get this high potential electricity for therapeutic purposes is through the induction coil. You can also get it from the static machine, and that is better for some work, but for therapeutic work the coil is the most satisfactory thing. I will explain how the coil is made. If you have a plain iron bar such as I show you, and put a coil of wires round it in the way I am doing, it does not alter the iron bar at all, but if I pass a current of electricity through the coil, the iron bar becomes a magnet at once (Fig. 6).

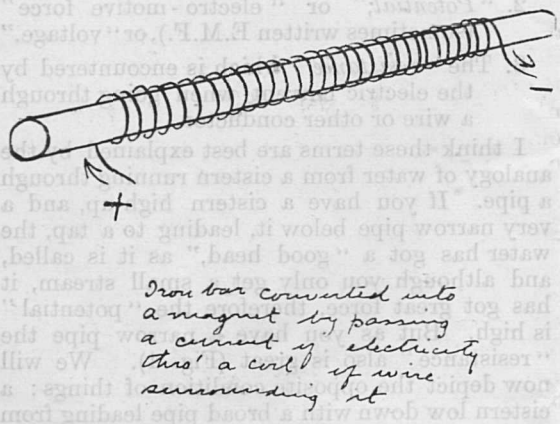


Fig. 6.

If you have two coils of wire and put one inside the other, and make the current pass through the primary or inner coil, you can see by the deflection of the galvanometer needle that a current is set up in the secondary or outer. Therefore, if you pass a current from any primary source through this primary coil you make the iron bar it surrounds a magnet, and at the same time you set up a current in the secondary coil which is bound round outside it. If you have the two things together in the middle, *i.e.*, the magnet and the current, the result is much intensified, and you get a current of high potential in the secondary

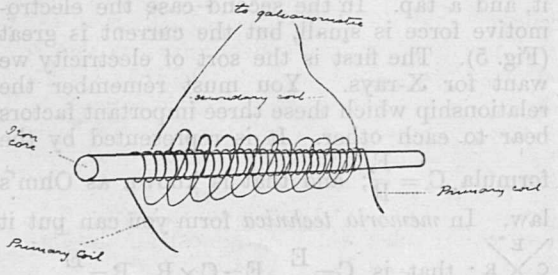


Fig. 7.

circuit (Fig. 7). It also depends to a great degree on the method of wiring of the primary and secondary coils. But it is only at the moment of make and break that the secondary current is set up. Therefore, you want some arrangement to act as an interrupter. And the best interrupter to use for practical purposes is perhaps the mercury motor interrupter. A motor consits of a magnet, with its north and south poles, between which what is called the "armature" is caused to revolve. The armature consists of a number of different magnets set on a central axis. You have a whole lot of temporary magnets in the armature, and the wiring is so arranged that the north poles are always on the north side of the motor magnet, and the south ones on the south side (Fig. 8).

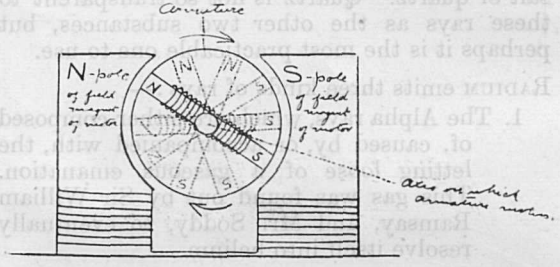


Fig. 8.

I will show you by an experiment what that means. Here I have suspended an ordinary compass needle. You will remember that like magnetisms repel, and unlike attract; so if I put the north pole of this magnet near the north pole of the suspended needle it repels it, and causes the needle to revolve. On that principle the motor is contructed. You get a series of these magnets on a central axis, and as the north poles of these come near the north pole of the motor magnet they are repelled and driven round on that principle. At one end of the armature is a crank, and there is a needle which dips into a cup of mercury; the crank lifts the needle up and down against the action of a copper spring. What happens is, that the main current goes into the mercury, and when the motor is revolving it dips the pointer into the mercury; the current is made, and it goes round and completes the circuit. But unless you did something where the pointer leaves the mercury you would have some sparking from the surface of the mercury. Therefore, above the mercury you have either water or a mixture of spirit and water; and that tends to prevent sparking. and also prevents the mercury being too quickly oxidized (Fig. 9). The source

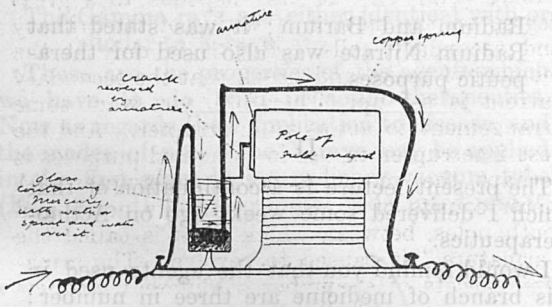


Fig. 9.

of your electricity may be from the mains; from a battery of primary cells, or from a battery of secondary cells (Fig. 10).

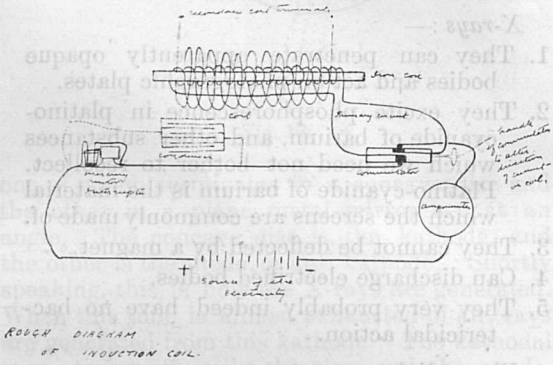


Fig. 10.

Here I show you a device called a *commutator*. If you have a current going in the direction you do not want it, you can by this means reverse it by turning the handle. The construction of all of them is on the same principle. In each case the terminals end up in metal fixtures, and by this handle which you turn round you can, if you desire, reverse the current. A brass pillar bears against the brass plates on the commutator, which will reverse the direction of the current going through the coil when it is turned round. Here I also show you an ampèremeter, and another device is introduced in the diagram, known as the condenser. The action of the condenser must be explained. If I rub a piece of sealing-wax with flannel it becomes negatively electrified, and if I bring it to touch a suspended pith ball, it first attracts and then repels it, because the ball also becomes negative. If I now rub a glass rod with silk the rod becomes positively electrified, and on approaching the pith ball it is attracted. This shows that like electricities repel and unlike attract each other. It is on this that the action of the condenser depends. I told you it was only at the moment of make and break that a current was set up in the secondary coil. Not only does it depend on the "make" and "break," but on the suddenness of that "make" and "break." For that reason the "break" current is the important one. You can understand that on making the passage of the current through the system of wires it takes an appreciable time to develop, and is not such a very sudden thing after all. But when the current is broken it is absolutely instantaneous; therefore, it is far more effectual. The condenser is a device introduced so as to make the "break" still more sudden. At the "break" the current is unable to get across from the mercury to the pointer in the interrupter, and so it runs into one side of the condenser. As unlike electricities attract, this + electricity will induce − electricity in the other side of the condenser; and it induces it so strongly that, although the opposite side of the condenser is on the minus side of the circuit, the ordinary potential becomes reversed in this part of the circuit, and a sort of back-rush is induced which has to be overcome when you are "making" your current again.

The condenser consists of films of tin foil, separated from each other by paraffin paper or some insulating material of that sort (Fig. 11).

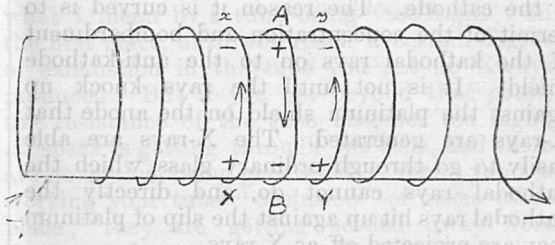


Fig. 11.

In the piece of wire A B *self-induction* causes a reverse current to be set up in the coils xX and yY next to it, for as like electricities repel and unlike attract each other, the electricity at B attracts + electricity at X and Y, and *vice versa* at x and y. So that in the modern induction coil every device is used to make the "break" connect the effective one, for self-induction makes the "make" current more slowly developed still.

Next you have a high vacuum tube (Fig. 12). Here is your tube, which is almost an absolute vacuum. If you pass electricity through a simple tube which contains air at ordinary pressure, you get nothing but a spark passing.

I have a series of tubes here which have been exhausted to various degrees. In the first tube

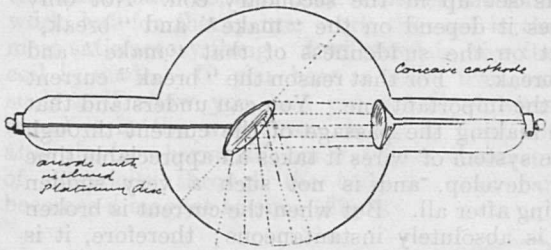


Fig. 12.

a shower of sparks will pass along from one end to the other, just as in ordinary air there has been no exhaustion. With a slight exhaustion there is a violent stream between the ends. In the next one, higher still, you will see that at one end of the tube the violet stream stops short at a considerable distance from one of the electrodes. In the next one, with still more exhaustion, the light becomes diffuse; it is a fluorescence, and there is a stratified effect. In the next tube, exhausted to a still higher degree, the fluorescence is still more marked, and those green rays which you see are the effect of kathodal rays. The concave electrode is the cathode. The reason it is curved is to permit of the concentration and bombardment of the kathodal rays on to the anti-kathode shield. It is not until the rays knock up against the platinum shield on the anode that X-rays are generated. The X-rays are able easily to go through ordinary glass, which the kathodal rays cannot do, and directly the kathodal rays hit up against the slip of platinum they are projected off as X-rays.

I would now like to show you this ultra-violet lamp working. The objection to it is that it is rather noisy, but the advantage is that there is no heat practically about it at all. Here are the terminals coming from the coil into this box containing a condenser. It is known as an iron spark lamp. At the bottom is a condenser. As soon as the current gets here it prefers to run into the condenser to jumping across the air between the iron terminals of the lamp, until so much electricity has accumulated that it bursts across the gap and causes a spark. This happens so rapidly that the light seems almost continuous.

NOTE.—The radium shown was in the form of Radium Bromide, and a compound salt of Radium and Barium; it was stated that Radium Nitrate was also used for therapeutic purposes.

II.

The present lecture is a continuation of that which I delivered some weeks ago on Actino-therapeutics.

I would remind you that the agents used in this branch of medicine are three in number: X-rays, Finsen light (and in Finsen light we include the ultra-violet rays), and lastly, emanations from radium. I will write on the board the pecularities of these various sets of rays. Perhaps the X-rays are the most important of all.

X-rays:—

1. They can penetrate apparently opaque bodies and act on photographic plates.
2. They excite phosphorescence in platino-cyanide of barium, and other substances which we need not bother to recollect. Platino-cyanide of barium is the material which the screens are commonly made of.
3. They cannot be deflected by a magnet.
4. Can discharge electrified bodies.
5. They very probably indeed have no bactericidal action.

Finsen light:—

1. It has a strongly actinic action.
2. It can discharge bodies which are negatively electrified.
3. It has a bactericidal action (as opposed to the X-rays).
4. Glass is opaque to it. Ice, rock-salt, and quartz are transparent to it. The last of these features is important because, of course, it is of no use having a glass lens at the end of a lamp. Quartz is the most convenient material.

Radium:—

This is less important than Finsen light, or the X-rays in my opinion. It has three sorts of rays: the Alpha, the Beta, and Gamma rays.

The Alpha rays constitute about 99 per cent. of all the emanations of radium; and they consist of, or are caused by, or are accompanied by, a gas, which gas, after keeping for some weeks, turns into helium.

The Beta rays are identical with, or similar to, the Kathodal rays.

The Gamma rays are either identical with or similar to X-rays.

Those are the properties of the agents which we have to do with in actino-therapeutics. Now as regards their application to disease, and the modes of use. The X-rays may be applied in the first place by an ordinary vacuum tube (Fig. 13). It has two metal rods fused into it,

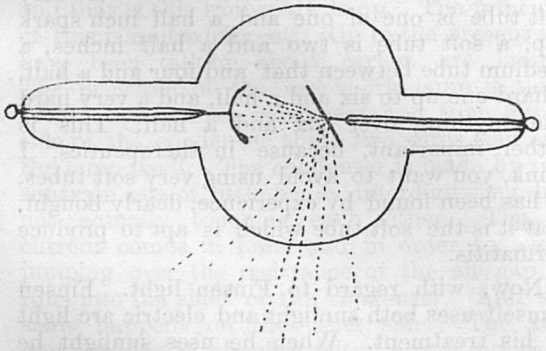


Fig. 13.

one of which terminates in a concave disc and the other in a plane metal mirror set at an angle. The concave disc is the kathode, and the other is the anode, or anti-kathode. Shortly speaking, this is how the X-rays are generated. When this tube is almost exhausted of air, rays are generated from this kathode. The kathodal rays coming off, strike the glass and the anode, and anything else inside the tube. The kathodal rays have no power to penetrate the glass to get outside the tube. Most of them are focussed to hit the mirror, and where they hit the mirror X-rays are generated. So X-rays may be applied from a simple focus tube; but when you are applying X-rays in that way you must be careful to do so only after some precaution. Suppose you have a small tumour to which you wish to apply the rays, as the rays emerge many of them will be worse than useless, because they will cause dermatitis in the surrounding skin. Therefore you protect the surrounding parts by placing on them a piece of lead foil, through which has been cut a hole of the size of the tumour. There is another device for avoiding dermatitis in the surrounding parts. It is known as Cossor's tube. The principle is exactly the same (Fig. 14).

But in order to prevent the rays from penetrating where they are not wanted most of the tube is made of lead glass, the lead, of course, more or less deterring the passage of the rays. All except the bottom end is made of lead glass, and that end is made of sodium glass. The X-rays generated and shot against the oblique mirror are able only to penetrate the sodium

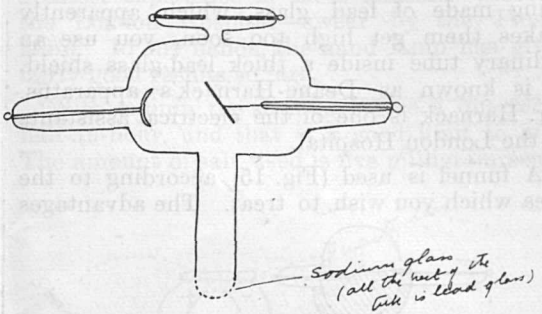


Fig. 14.

glass, so that the point of exit is restricted. These tubes are made of many sizes and shapes, from as small as the end of the little finger. When these tubes are working, they give off a blue fluorescence where the lead glass is, and a green fluorescence where the sodium glass is, But they are constantly getting too high, especially in cold weather. When a tube gets too high, it means that you need to force more current through it to get it to work, and consequently you are apt to break your tube. With the view of overcoming that difficulty, a little extra tube is put in. I will tell you what I mean by a tube being "too high." In the first place, until you reach a certain degree of exhaustion in the tube you get no X-rays produced. But if you get beyond that point, the resistance of the tube becomes too high; no spark is getting through the tube, and there are no X-rays being generated. When you are working your tube "occlusion" of gases takes place; they are getting settled away from the general atmosphere of the tube, either on the glass or on the metallic parts; more and more gets settled so that your vacuum gets higher, and at last it gets so high that no rays are generated at all. Therefore there is an extra arm put on the side, in which are fused two thick metallic bars, made, I believe, of palladium. The theory of the working of the tube is that the gases get occluded on these thick metal bars and in order to free them, instead of attaching your wires *here* for working the tube, you take them away and fix them to either side of this little tube, and go on letting the current pass through there until the tube again gets low enough to work properly. It does not act very satisfactorily at first, and later on it does not seem to act at all. Therefore those are more or

less unsatisfactory tubes, although they are a real and very scientific advance on the older ones. There is another modification which aims at the same thing, but instead of the tube being made of lead glass, which apparently makes them get high too soon, you use an ordinary tube inside a thick lead-glass shield. It is known as Deane-Harnack's apparatus. Mr. Harnack is one of the electrical assistants at the London Hospital.

A funnel is used (Fig. 15) according to the area which you wish to treat. The advantages

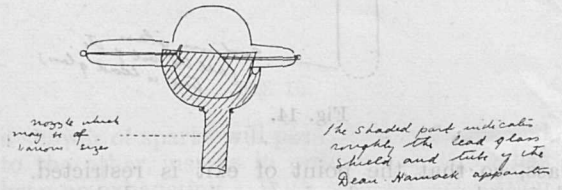


Fig. 15.

of this are three in number. First of all, breaking of the tube is avoided, and tubes are an expensive item. Secondly, each patient can have his separate nozzle kept for him, and that is useful, especially for private patients. Thirdly, the risks of dermatitis are avoided.

I have been referring to hard tubes and soft tubes, and though I have explained from the scientific point of view what I mean, I would like to explain a practical method of finding out whether a tube is hard or soft, apart from breaking it. I think the most practical method is the alternative spark method.

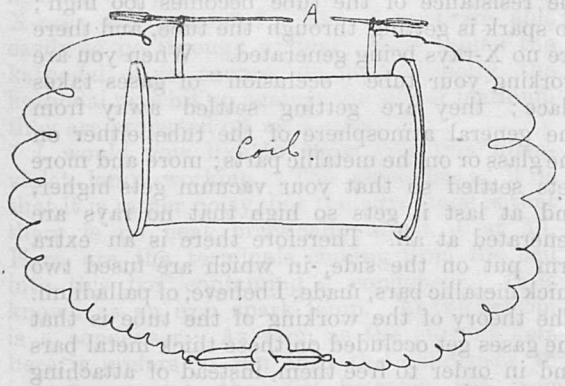


Fig. 16.

The electrodes are supplied with two metal wire rods, having vulcanite handles, by which you can adjust the distances of the electrodes from each other. The way you use them for this purpose is as follows:—Supposing the tube were hard, the current instead of going through the tube would jump across the spark-gap A. If the space A is six inches, and supposing that instead of going through the tube you get a spark going across this six inches, and then you shift the electrodes a little further away, and it ceases to go across the spark-gap, you will know that you are working with a six-inch tube. A very soft tube is one of one and a half inch spark gap, a soft tube is two and a half inches, a medium tube between that and four and a half, a hard one up to six and a half, and a very hard one anything over six and a half. This is rather important, because in therapeutics, I think, you want to avoid using very soft tubes. It has been found by experience, dearly bought, that it is the soft tube which is apt to produce dermatitis.

Now, with regard to Finsen light. Finsen himself uses both sunlight and electric arc light in his treatment. When he uses sunlight he employs a big lens, plane on one side and convex on the other, and the interior is filled with a light blue ammoniacal aqueous solution of copper sulphate. It is put in there to absorb the infra-red rays, otherwise a burn would be caused. There is no use in saying any more about that because we shall probably never be able to rely on our supply of sunlight in this country. Finsen uses for electricity the carbon arc lamp. The lamp is suspended from the ceiling (Fig. 17).

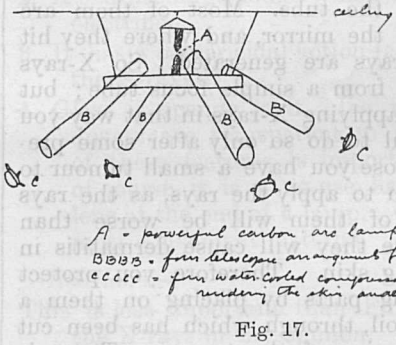


Fig. 17.

There are fixed four telescopic-looking condensers, fitted with quartz lenses, and filled with water; they also have an outer circulating jacket of cold water to keep them cool. The glass compressors are important, because without them the treatment would do no good; you must render the parts anæmic by means of pressure. There is a smaller variety of Finsen lamp, called the Finsen-Reyn lamp.

I show you here a lamp made by Dowsing, which I had sent here for trial. It has not been very successful in my hands so far. There is another lamp, which is called the Lortet-Jenoud, which is on the same principle, but differs in detail. It is matters of detail which are important in actino-therapeutics.

We now come to an important modification, and that is this iron spark lamp. The principle of this is quite different. Up to the present we have been talking about carbon arc lamps. The principle of the iron-spark lamp is this: Inside this box is a condenser, and from either side of the condenser these two wires lead into the lamp itself. The condenser is made by two separate sets of little plates, interdigitating, but not actually touching each other. The + current comes in here, and in order to avoid jumping over the resistance of the air gap, it runs into the sides of the condenser. And the same happens on the other side. The two opposite kinds of electricity, attracting each other, remain some time, until they become so accumulated that something has to happen. You get an intensely violet spark jumping across the gap, and you get the ultra-violet rays also generated. With this iron spark-lamp there is at all events one disadvantage—that is, the noise it makes. Opposed to that is the advantage that the patient can him or herself use it by holding it to the face or other affected part. It is also claimed that it is richer in ultra-violet rays than is the Finsen lamp. This is used almost to the exclusion of all others at St. Bartholomew's. It is made by Leslie-Miller (Fig. 18).

The radium salts used in medicine are the bromide, the nitrate, and the compound salt of radium and barium. You can apply radium either in a little glass tube like *this*—I have cured two rodent ulcers with it—or you can have it in a specially made vulcanite holder.

Another practical point is the time that the sittings should take. With Cossor's modification, or that of Deane-Harnack, you apply the part to be treated right up against it. But with an ordinary tube such as this you would have it six or eight inches away. The time of the sitting should be ten to fifteen minutes. You should carefully watch your case; there should not be too much redness set up, though you need to set up a certain amount of reaction. With the Finsen light a great point is to render the part anæmic by means of pressure. With this carbon arc lamp the sittings take from half-an-hour to one hour. With the spark lamp the sitting is up to ten minutes. That would seem to prove that this was by far the more efficient lamp of the two. But the people who have had the greatest experience in these matters—those at the London Hospital—swear by the Finsen lamp. In my hands, the hand lamp has given fairly good results so far.

With radium the sittings I give a quarter to half-an-hour, and that is a good limit to give. The amount of salt used is five milligrammes of

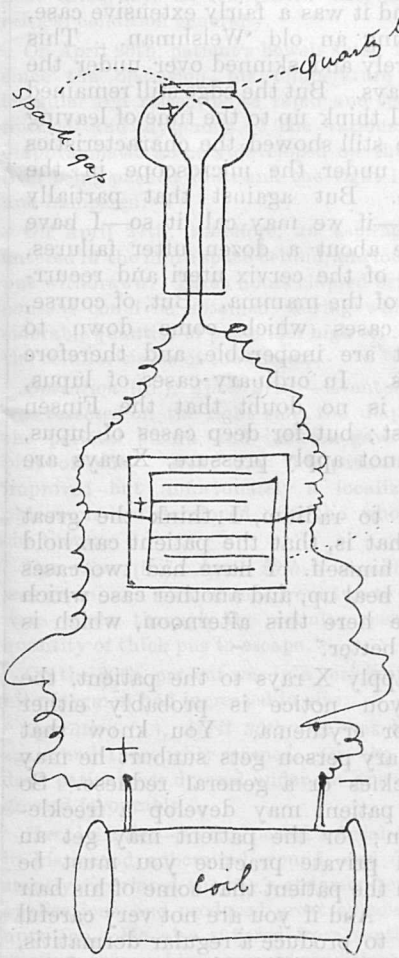


Fig. 18.

radium bromide. Here is a mixed salt of radium and barium, having a strength 7,000 units of radio-activity. These various agents are looked upon as more or less interchangeable. This is more or less true, they are; but there are various cases which are more suited to one agent than to another.

The three diseases to which actino-therapeutics is particularly applicable seem to be lupus, rodent ulcer, and certain cases of cancer. And I wish to speak very carefully here, because so much nonsense has been talked about X-ray treatment for cancer. I think one can say that the X-rays ease the pain and retard the growth in some cases of cancer. Mr. Lane sent me a case of epithelioma of the sole of the foot. There was no doubt that it was epithelioma; it was examined microscopically. The plantar fascia was exposed, and it was a fairly extensive case, the patient being an old Welshman. This healed up entirely and skinned over under the influence of X-rays. But the edge still remained thickened, and I think up to the time of leaving the hospital he still showed the characteristics of epithelioma under the microscope in the thickened edge. But against that partially successful case—if we may call it so—I have had somewhere about a dozen utter failures, with carcinoma of the cervix uteri and recurring carcinoma of the mamma. But, of course, most of the cases which come down to my department are inoperable, and therefore almost hopeless. In ordinary cases of lupus, I think there is no doubt that the Finsen light is the best; but for deep cases of lupus, where you cannot apply pressure, X-rays are better.

With regard to radium, I think the great advantage of that is, that the patient can hold it on the lesion himself. I have had two cases of rodent ulcer heal up, and another case which I think will be here this afternoon, which is rapidly getting better.

When you apply X rays to the patient, the first change you notice is probably either pigmentation or erythema. You know that when an ordinary person gets sunburt he may get either freckles or a general redness. So X-rays on a patient may develop a freckle-like pigmention; or the patient may get an erythema. In private practice you must be careful to warn the patient that some of his hair may come out. And if you are not very careful you may go on to produce a regular dermatitis, and if you do it is very difficult to cure. Some people who have had this dermatitis have developed epithelioma. There was a very bad case at St. Thomas's. I am told that the medical officer in charge of the X-ray department there developed dermatitis, and he died of multiple epitheliomata. Certainly most of the cases I have heard of who developed chronic dermatitis do not seem to be doing anything towards recovery.

We will now have in some cases. Here is a woman with lupus. It was a very extensive case indeed. There were thick crusts over the ear and over the face and on the chin. A point of interest is that the patient had been treated for about eighteen months with the X-rays, but they had done no good whatever. And so we treated her with the ultra-violet light. She has been under treatment three months, and it has nearly all cleared up.

Here is a lady with rodent ulcer, very nearly cured. It has been treated with radium. She has been under treatment fourteen weeks, and has held the radium to the lesion for half an hour at a time.

Here is a man with mycosis fungoides. There was a huge ulcer, and rather a deep one. The nipple was increased to the size of my little finger; a weeping red growth. There is no cure known for mycosis fungoides. We have treated it with the X-rays, and it has cleared up entirely; you can hardly call it scar tissue I think it is the first case of the kind in England to be treated with X-rays, and the second which has been treated in that way at all. There is another small place on his back which is still under treatment.

Here is a man whom Mr. Dunn sent to me as the ulcer on his hand would not heal up. He had had the ulcer fifteen months, and it was a suspicious-looking lesion. Mr. Dunn had excised it two or three times, but it recurred, and so he was sent to me. It is beginning to heal up, and is already much smaller.

(NOTE.—It eventually healed up entirely).

Here is a man, the subject of sycosis, and he had been under the care of Sir Cooper Perry, and then under Mr. Steward, for chronic nasal discharge for more than a year. You see it has cleared up nicely after the application of X-rays, combined with static electricity. He has had the condition twenty-four years.

(NOTE —Later it was found that the cure did not persist; at the present time there are very decided signs of a relapse).

FINAL NOTE.—In these foregoing lectures I have given my personal experience with the various apparatus mentioned. It by no means follows that what I have failed with should fail in more skilful hands. I feel, in the present evolutionary state of actino-therapeutics, that the plain statements of unbiassed observers should be not without their value.

A Case of Remarkable Vitality.

I have been induced to publish the following case for two principal reasons.

In the first place, it illustrates very well the many and distressing sequelæ which may follow on a simple case of appendicitis or appendicular abscess.

The second, and most conspicuous point is its illustration of the great vitality and endurance exhibited by the patient in question.

This patient, R. T. J., a Yorkshire boy, 14 years of age, the only child of well-to-do parents, was on admission well grown, though spare, and of good physical development, intelligent, plucky, self-willed, and decidedly north-country in his brusque manner, speech, and matter-of-fact deportment.

There was no history of previous appendicular attacks —nor indeed of illness of any kind.

Patient was admitted on April 22nd, 1904, seven days after the commencement of an attack of appendicitis, which was severe and had the usual characteristics —pain in the right iliac fossa, some sickness, fever, and constipation.

On admission.—Temperature 99·8°, pulse 100, respiration 24. There was a painful fluctuating swelling in the right iliac region, masking the fold of the groin, iliac crest and spine.

His general condition was fairly satisfactory. He had not been sick for three days, and his bowels had acted well ever since admission. In his chest the only adventitious sound was a harsh, localised, systolic bruit heard in the pulmonary area.

Operation (i.), *April 22nd.*—A few hours after admission patient was anæsthetised; he struggled somewhat during the preliminary stages, and it was soon noticed that the iliac swelling had become much less marked. This was attributed to the general abdominal relaxation under an anæsthetic, though the possibility of a rupture into the general cavity was discussed at the time.

On opening the abdomen in the appendicular region some foul pus escaped, but not so great a quantity as one was led by the physical signs to expect. The residual pus also moved markedly on respiration. No communication between the abscess and peritoneal cavity could be found, however, so the former having been cleansed, an inflamed perforated appendix and free concretion were removed, a tampon inserted, and patient sent back to the ward.

After this operation the boy's condition became most unsatisfactory. Pulse weak and thready, 125, temperature 98°, respiration 40. Face, sweating, grey and sunken; abdomen distended, rigid and painful. He was repeatedly sick and hiccoughed at intervals.

Operation (ii.), *April 23rd.* — Patient was therefore anæsthetised again and the general abdominal cavity opened slightly to the right of the mid-line, a large quantity (1—2 pints) of pus escaping. The cavity was thoroughly washed out and drained, patient being returned to bed in a moribund condition—pulseless, cold, sweating, with dilated pupils and a sunken abdominal face. Despite his grave condition he demanded comic papers half an hour after the anæsthetic, and amused himself by reading the jokes and looking at the pictures in the intervals of his sickness. The usual treatment, hypodermic stimulants, frequent infusion and enemata rallied him considerably. Though for the next three days he vomited at intervals and was in a critical condition generally.

On April 26th, patient's bowels acted for the first time since the operation, his temperature remained very irregular and raised, pulse rapid and feeble, respiration hurried and dyspnœic. The various signs of subdiaphragmatic abscess developed on the right side, the liver being pushed down and the right lung compressed and hampered.

On April 27th, therefore, an aspirating needle was entered in the ninth space behind, and foul, watery B.C.C. pus withdrawn. Three hours elapsed before the parents' consent could be obtained, during which time a considerable quantity of pus under high tension escaped into the cellular tissue of the thorax.

Operation (iii.), *April 27th.*—Eventually the 9th rib was resected on the right side, the diaphragm sewn to the parietal pleura, and incision gave exit to quite a pint of pus. Next day the patient seemed much improved but unfortunately a localized cellulitis or phlegmon had developed over the whole right side of the thorax.

Operation (iv.), *April 29th.* — Again an anæsthetic was given, and six incisions from two to four inches long were made through the cellular tissues, allowing a quantity of thick pus to escape.

On the 30th, patient was in a very grave condition and his phlegmon had increased in size.

Operation (v.), *April 30th.*—It was therefore incised again and thoroughly scraped. On the three following days patient was dressed under an anæsthetic and progressed favourably.

Fæcal fistula.—At this period a fæcal fistula developed in his second adbominal wound, and discharging constantly excoriated the boy's abdomen terribly in spite of applications, and produced great emaciation from malnutrition. He also suffered from septic diarrhœa, and was in a thoroughly sapræmic condition.

Towards the 11th May, signs of a re-accumulation under the diaphragm on the left side were noticed. The splenic dulness being greatly increased and the left chest compressed and inhibited; on aspiration in the 8th space pus was withdrawn.

Operation (vi.), *May 11th.* — The 8th left rib was immediately resected and a large subdiaphragmatic abscess dealt with. Patient's general condition improved after this operation. The pulmonary bruit was noticed

to have grown much louder and harsher than formerly, which fact, taken in conjunction with a continued temperature and general septic condition made one suspicious of infective endocarditis. Happily this fear was groundless. The fæcal fistula showed no signs of closure, patient's emaciation becoming extreme (numerous lineæ albicantes being developed over his joints, buttocks, etc.). He was still greatly excoriated and had developed sores on his back in spite of a water-bed, etc. His general condition was decidedly worse. Pus was still produced in large quantities, though practically there was no evidence of lardaceous disease. It was therefore decided that closure of the fistula was his only chance of recovery.

Operation (vii.), *May 24th.*—Under an anæsthetic the fistula was found to be of large size and in connection with the ileum close to the colon. It was sutured and the skin and tissues partially united over it. Half an hour after this operation the boy, who was constantly in a ravenous state of hunger, procured an apple from one of the other patients and had nearly finished it before being detected. This did not affect his recovery, however, the gut healed and patient began rapidly to regain weight, the constant irritation from intestinal contents being also removed, much to his relief. Physical signs, however, again developed in the right chest indicative of an empyema, due no doubt to direct spread from the previous subdiaphragmatic abscess.

Operation (viii.), *June 7th.*—The eighth rib on that side was therefore resected, the pleura incised, and a large collection of pus evacuated and drained.

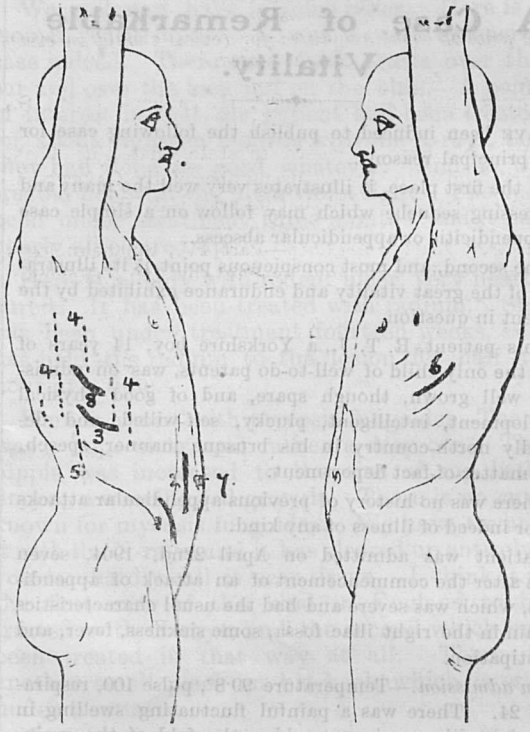
After this, patient's last operation, he made an uninterrupted recovery. His temperature, pulse and respiration fell to normal and remained there. He gained flesh with great rapidity; all the wounds united, the bedsores healed, and eventually he became strong enough to get up on a couch and ultimately walk—being discharged in a convalescent condition on July 12th, 1904, after three months' confinement to the ward.

Throughout his illness the boy remained cheerful, hopeful, and very matter of fact, consenting to any operation without complaint and even taking an interest in what was going to be done to him.

When one considers the amount this patient has undergone — eight considerable operations with their unavoidable shock and the fright and danger attached to anæsthetics, the pain and annoyance of constant dressings, a fæcal fistula with accompanying prolonged waste of nutrition and irritation from excoriation, general profound septic poisoning from abscess and phlegmon producing continued diarrhœa and cachexia, together with prolonged confinement on his back, rendered worse by bedsores, famishing hunger and sleeplessness—one must consider this case to be one of remarkable stamina and vitality.

I insert the accompanying diagram and list of operations to give one a bird's eye view of the case.

I am indebted to Mr. T. B. Layton for his admirable report.



Operations:—

1. April 22.—Appendicular abscess drained; removal of the appendix.
2. " 23.—General suppurative peritonitis; abdominal cavity opened and washed out.
3. " 27.—Subdiaphragmatic abscess on right side; resection of ninth rib.
4. " 29.—Phlegmon — six incisions over side of thorax.
5. " 30.—Phlegmon—incised again and scraped.
6. May 11.—Subdiaphragmatic abscess left side; eighth rib resected.
7. " 24.—Operation for closure of fæcal fistula.
8. June 7.—Empyema right side; eighth rib resected.

R. G. A.

Change of Address.

S. J. Evans, L.D.S., from the Firs, Abergavenny, to Clarence House, Promenade, Cheltenham.

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Charles W. Randall, L.D.S., from Colchester, to 82, Bootham, York.

J. H. Targett, M.S., F.R.C.S., from 6, St. Thomas's Street, S.E., to 19, Upper Wimpole Street, W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Reviews.

The price of books submitted for review should in every case be stated.

Devices and Desires. By P. H. Lulham, M.R.C.S., L.R.C.P.

We have been requested to state that this book, reviewed by us in a previous number of the Gazette, is on sale at Grattan's and that its price is 3s. 6d.

Atlas of Human Anatomy—Part IV., Splanchnology. By Carl Toldt, translated by Paul, pp. 156. (Rebman, Limited) 9s. 6d. net.

This is the fourth part of a work which bids fair to be monumental — the other parts having already been reviewed in these pages. To the student who prefers to learn his anatomy from pictures and diagrams these figures are as good as could be obtained, though we have always maintained that the best diagrams are always those made for oneself and by oneself. What we especially like are the series of dissections of the tongue and of the muscles of the perineum—which regions are especially hard to understand. There is also a good diagram of the vessels at the root of the lung, in which the arteries and veins, appropriately coloured, show up very well, so that we could wish the author had not been so sparing of his red and blue in other diagrams; as where used these colours are very successful, more so than the brown with which the muscles are coloured, as here the tendency throughout the book is to obscure the definite edge of the muscles. A few more horizontal sections of the abdomen showing the peritoneum distinctly coloured would have been useful, though a good series showing the development of this membrane is given.

An excellent index exists and adds greatly to the usefulness of the volume; but we should like to point out for future editions, that a section of pavement epithelium is not much good as showing its character without also a surface view, and that *radices dentis* is not correctly translated into "roots of teeth." We can confidently recommend this book as a good work of reference enabling any particular relation to be discovered at a glance without the usual wading through many lines of text.

Cleft Palate and Hare-Lip. By Edmund Owen, 111 pp. "Medical Monograph Series." (Messrs. Bailliére, Tindale & Cox.) 2s. 6d. net.

This short monograph has been written with the object of introducing more generally to the English surgical world the cleft palate operation of Dr. Brophy, of Chicago. This surgeon operates on the palate at any age from two weeks to three months, and, not content with making mucoperiosteal flaps, he actually pulls the two superior maxillæ together with wires passed through the hard palate and twisted over tension plates. The hare-lip is done some time after the palate; or, if no cleft exists in the latter, Mr. Owen closes the lip any time after the tenth day of life. In discussing the etiology of these deformities, we are told that the form and shape of the lips and palate should be complete at the tenth week of fœtal life—while the fright, to which the mother often attributes her baby's cleft palate, generally occurs in the later months of pregnancy. Very full and minute directions are given, both as to the different stages of each operation and as to the after-treatment; the result being a very useful handbook to a very difficult operation.

Nursing News.

Matron's Office.

It is with deep regret that we have to record the death by drowning of Nurse Elise Riley, Head Nurse in Stephen, on August 15th. Nurse Riley only left the hospital for her holiday on July 30th, and the news of the lamentable accident by which she lost her life came as a great shock to her fellow-workers, by whom she was much liked, and the greatest sympathy was expressed on all sides with her parents in their sad bereavement. The funeral took place at Strood on August 19th, and was attended by several members of the nursing staff.

On August 2nd Nurse Mackenzie, Head Nurse in Astley Cooper, and Nurse Fox, Head Nurse in Bright, left the hospital on completion of their three years' training.

On August 4th Miss A. T. Bell (Sister Anne) entered upon her duties as Hospital Housekeeper. Miss Bell received her training at Guy's in 1901, and has since been Night Superintendent at the Evelina Hospital.

On August 16th Probationer Leather was appointed Head Nurse.

On August 17th, Nurse Spink left the hospital on completion of her three years' training, to take up her duties on the Private Nurses' Staff, and Probationer Fraser was appointed to succeed her as Head Nurse in John Ward.

On August 23rd, Miss E. Wise (Sister Eleanor) was appointed Probationary Sister. Miss Wise completed her three years' training at the end of last year, and has since been on the Private Nursing Staff.

Appointments.

Civil.

Floyd, S. G., M.D. Lond., F.R.C.S., has been appointed Certifying Factory Surgeon for the Grays District, Essex.

Frith, Walter S., M.B., B.C. Cantab., has been appointed Resident Medical Officer to Felstead School and Head of the Junior House.

Handley, W. Sampson, M.S. Lond., F.R.C.S., has been appointed a Hunterian Professor of Pathology in the Royal College of Surgeons of England.

Lister, T. D., M.D. Lond., M.R.C.P., has been appointed Honorary Consulting Physician to the Benevolent Fund of the National Union of Teachers.

Outred, C. D., M.R.C.S., L.R.C.P. Lond., has been appointed Medical Officer for the Grays District of the Orsett Union, *vice* C. W. Gilbert, M.R.C.S., L.R.C.P. Lond., resigned.

In Lighter Vein.

EXTRAORDINARY COUNCIL MEETING.

DRESS REFORM.

FULL REPORT.

Dr. T—Y—R (Chairman): "Gentlemen, I have convened this meeting in order that we might discuss the important question lately raised in the *B.M.J.* as to the advisability of our profession adopting some distinguishing mark in its dress."

Master T——Y H——KS: "I think it is high time something was done. Why, only yesterday I was mistaken for an ordinary man."

Mr. S——S: "How very remackable!!!"

Sir A—— F——: "Ever since I took to wearing the Prince of Wales's feathers as a tie-pin I have never been mistaken for anyone but myself or—er—the King."

Mr. G—— -B——: "Ah, but fine feathers don't always make fine Golding-Birds."

Mr. O—M—D: "Really, gentlemen, this is more than a personal matter. Let's look at it from a wider field of vision. The curate has his white collar, the South Eastern porter his red tie, the teetotaller his blue ribbon. We should indeed be colour blind not to see the great desirability of this reform."

Dr. SH——W: "Oughtn't we first to try and see ourselves as others see us?"

Mr. L——E: "Ah, SH——W, it's obvious you haven't been in my new theatre. But why not wear radium buttons? Then we should be obvious even in the dark, shouldn't we?"

Dr. F—RS—TH (politely): "Quite a Willie-o'-the-Wisp idea."

Mr. F——GE: "Of course, every man must think according to his lights. Though I have never advocated putting one's light under a bushel, I take it that one of Dunn's 3s. 9d. hats would be cheaper and more tip-top."

Dr. F——CH: "Hear, hear!!!" (purringly).

(Here Mr. D——n protested that, although they mightn't think it, he never gave more than 2s. 11¾d. for his hats.)

Mr. L—C—S: "It's a natural step from buttons to boots. I supine that boots are the most noticeable item in a man's dress, so I beg to move——." (Here Mr. L—c—s became absorbed in a brown study of his black boots.)

Dr. H—RR—KS: "Ma own idea is a combination——."

The CHAIRMAN: "Order, order."

Dr. H—RR—KS: "I repeat, ma idea is a combination of the useful with the artistic."

DR. E—S—N: "Although as D——n I have adopted the motto, 'Do nothing by calves,' I do think if I wore at least semi-clerical dress—say a bishop's gaiters—it would inspire greater confidence in the minds of anxious parents."

Mr. S—H—L deprecated the idea of trousers falling into disuse. He thought that provided they were well turned up, nothing was more effective from every point of view.

The S——L R——R: "I oppose the whole idea. I hold that address is everything—dress nothing. From my youth upwards I have always been taught that it's manners that maketh the man. I emphatically deny that I have been mistaken for a bargee more than twice."

The shouts of incredulity here raised awakening Mr. L—c—s, the meeting was adjourned.

THE ONLOOKER.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Pathological Drawings by the late Dr. Moxon.

DEAR MR. EDITOR,—I am sure that all Guy's men will be glad to learn that the beautiful series of pathological drawings by the late Dr. Moxon are not in such a bad condition as was thought to have been the case according to a recent paragraph in "Passim." The drawings were taken down some time ago owing to the damp having penetrated one of the walls of the post-mortem room and having very rapidly attacked the pictures. The larger number are intact and merely require cleaning, while only a few—and these, fortunately, the least valuable—have been so damaged by mildew as to be useless.

It is proposed that all the drawings shall be cleaned and remounted, and a suggestion has been made to place them in the new museum where they would be more readily available to students and others than they have hitherto been in the post-mortem room.—I remain, Sir, yours sincerely,

JOHN FAWCETT,
Curator of the Museum.

Efforts.

[The following are examples of answers given by candidates in a recent examination in Physiology. We have been pledged to secrecy, and consequently wild horses (the metaphor is not our own) would not be able to drag from us the name of the ancient and venerated institution under the auspices of which the examination took place.—Ed.]

1. If the cornea is crossed in hot-cross bun fashion we can get at the lens which will slide out.

2. The intestines are arranged in a most beautiful manner.

3. The clavicle serves to improve one's appearance.

4. The clavicle or jaw bone forms the mouth. It can be moved about almost any road.

5. The clavicle is curved in female and straight in male; it is cartilage till the 21st year.

6. The bladder was developed for convenience.

7. The bladder is small in size but can be distended at will; it has an obleak valve.

8. The crystalline lens grows dim in the dark and you can hardly see anything in front of you.

9. The different kinds of sensation are pain and pleasure, *e.g.*, a wink of the eye and a cough.

10. The crystalline lens are placed about one-eighth of an inch from the yellow spot, they make the pupil of the eye contract when you look at anything far away or in the dark. They dilate the pupil of the eye when you look at anything in a bright light or next the eye.

11. The different kinds of sensation are Feeling, Moving, Smelling, Hearing, Speaking and Eating.

12. Sound waves are received into the lob of the ear. The pinpanum is a bony article which the waves vibrate against in the action of hearing.

14. Sound waves are made by breaking. Sound waves are only made when a person is sleeping. When we are asleep we breathe heavier and the epiglottis moves backwards and forwards and causes snoring.

15. White corpuscles never have a shape of their own because they cast out prongs at their will.

16. White corpuscles contain an amæboid, red do not.

17. The larynx is the place where the voice. It is very vulgar to speak whilst we are eating our meals.

18. Milk viewed under the microscope is seen to contain a number of tiny insects, also a number of oblong cells, it is therefore a perfect food.

19. Milk we get from herbacious animals and oxygen, H and nitrogen are contained largely in our herbs.

20. The food is forced through the intestines by a wave-like performance.

21. Villi and the entericus suckers and intestinal juice all assist digestion. The entericus suckers turn undigested food about. (Here there followed an ingenious diagram of an entericus sucker.)

22. The heart is a hollow muscular bag with the tri and bicuspian valves with a kind of lid which opens and shuts when air enters and leaves the heart.

23. The atlas enables us to say yes, and the axis to say no.

24. Lymph is a deleterious substance not found in man, however, it occurs in the calf, and is sold by Government in tubes as a protection for smallpox. This causes great irritation in man.

25. The femur fits into the acid tabulum.

List of Names for the Proposed Chapel Memorial.

Dr. Hilton Fagge.
Dr. Mahomed.
Dr. Moxon.
Dr. Wooldridge.
Dr. Carrington.
Mr. Davies-Colley.
Mr. Arthur Durham (Consultant).
Dr. Washbourn.
Dr. Braxton Hicks (Consultant).
Mr. Birkett (Consultant).

A. Ellis Durham.
J. Chadwick.
F. S. Hawkins.
— Bettington.
L. E. James.
T. H. Green.
F. J. Blewitt.
E. Stott.
W. McPherson.
L. A. Fothergill.
R. C. B. Shaw.

Clara Lumley.
Matilda Botwright.
Margaret Keogh.
Elizabeth Ling.
Susannah Lee.
Alice Linden.
Milly Lock.
Helena Peckham.
Annie Pinfold.
Kate Hands.
Rachael Roberts.
Frances Whitnell.
Agnes Cutting.
Mary Dance.
Constance Gale.
Eliza Herne.
Edith Wooll.
Margaret Cotton.
Constance Heygate.
Norah Wigney.
Alice Bailey.
Olive Barnard
Florence Lew.
Elise Riley.

Pass List.

University of Cambridge, August, 1904.

DIPLOMA OF TROPICAL MEDICINE AND HYGIENE.

J. C. B. Statham.

University of London, July, 1904.

FACULTY OF MEDICINE.

General Intermediate Examination for Internal Students.—C. A. Basker, T. E. A. Carr, K. H. Digby, E. W. Giesen, H. J. Henderson, J. E. Hodson, C. A. L. Mayer, W. P. H. Munden, E. L. R. Norton, H. J. Smith, G. F. Stebbing.

Special Examination in Organic Chemistry only.—M. M. Adams, H. R. Bastard, H. B. Carter, J. B. Dunning, R. C. V. Edsall, T. Evans, A. L. Gardner, K. H. Hole, H. I. Janmahomed, W. Johnson, H. C. Lucey, C. H. Marshall, B. McDermott, H. E. H. Mitchell, R. A. Rankine, D. Reynolds, H. A. Sanford, T. Stansfield, P. Seymour-Price, S. G. Tracy, V. Townrow.

External Student.—G. B. Harland.

Royal College of Physicians of London and Royal College of Surgeons of England, July, 1904.

EXAMINATION FOR DIPLOMA OF PUBLIC HEALTH.

S. C. Clapham, J. W. Gromitt, M. J. Rees, J. R. Steinhaeuser, J. C. B. Statham.

Final Conjoint Examination, July, 1904.

Medicine, Surgery and Midwifery.—*F. Alcock, *E. C. Hughes, *W. M. Mollison.

Medicine and Surgery only.—*F. Barnes, R. Felton, *M. Maher, *M. J. Mottram, *G. C. F. Robinson.

Surgery and Midwifery only.—A. Leeming.

Medicine only.—A. M. Benett, J. H. Clatworthy, C. J. S. Dismorr, C. P. Harvey, D. H. Richards, J. D. Thomas.

Surgery only.—*J. E. L. Bates, *C. E. Bartlett, *F. G. Goble, *S. D. Jacobson, *H. H. Jenkins, A. S. Littlejohns, *W. N. May, *E. C. Myott, *F. Rogerson.

Midwifery only.—J. M. Barrionuevo, H. M. Clarke, J. E. Collins, P. F. Minett, A. Morris, N. H. Oliver, *T. H. F. Roberts, R. P. Rowlands, S. M. Wells.

* Denotes completion of examination.

Second Conjoint Examination, July, 1904.

H. P. Aubrey, A. L. Foster, F. H. Fuller, P. V. G. Pedrick, J. T. Smalley, St. J. A. M. Tolhurst, J. N. Watson.

First Conjoint Examination.

Part I.—Chemistry.—C. C. Freer, V. P. Hutchinson, H. L. Power, N. P. Rodgers, O. B. Townshend.

Part II.—Practical Pharmacy.—A. M. Benett, A. H. Clough, H. P. Costobadie, J. E. Scales.

Part III.—Elementary Biology.—K. G. Haig, P. E. H. Patey.

Royal Army Medical Corps, August, 1904.

H. O. M. Beadnell, A. W. Gater, H. C. Winckworth.

Preliminary Science—Internal Students, July, 1904.

Entire Examination.—C. A. Wood.

Chemistry and Biology.—A. A. Greenwood.

Experimental Physics and Biology.—C. H. Crump, E. L. Elliott, G. F. Haycraft, J. L. Johnson, T. Lewis Jones, G. H. Peall, J. R. Perdrau, A. F. Sabin, C. Witts.

Chemistry only.—*W. S. Kidd, *W. E. Williams.

Experimental Physics only.—A. Archer.

Biology only.—A. L. Fitzmaurice, D. A. Mitchell, *R. A. Rankine.

* Denotes completion of examination.

EXTERNAL STUDENTS.

Chemistry and Experimental Physics.—W. L. Hibbert.

GENERAL INTERMEDIATE—INTERNAL STUDENTS.

S. J. Darke.

From the Gazette's Special Pathologist.

NOTICES.

H. J. H., Eastbourne.—This growth is a duct carcinoma of the breast. On section it consists of cystic spaces, probably resulting from dilated ducts, and these spaces are filled with papillary ingrowths. In many places these ingrowths have a simple structure, but in other parts there is very distinct malignant infiltration of the adjacent fibrous stroma.

PATHOLOGIST.

Sport.

Cricket.

GUY'S v. LONDON.

FINAL INTER-HOSPITAL CUP TIE.

This match was played at Honor Oak Park on the 21st and 22nd July.

London won the toss, Gibson and Standish starting their innings sent up 40 before Standish was well caught at point. Gibson was bowled soon after, but Burgess and Corry took the score to 100 when Wells caught the the former. Kaye did not give much trouble, but Salt stayed with Corry till lunch, when the score was 150 for 4. On resuming, 3 wickets fell for the addition of 10 runs, but Scott, Thomas and Linnell each got into double figures, raising the total to 216. Piper bowled very well, taking 6 wickets for 97. Wells caught two good catches.

Our innings was opened by Wyatt and Barber, who started scoring at a great pace, 72 were scored in 45 minutes, when Barber was caught at the wicket. Willan helped Wyatt to add 76 before being caught in the slips. Morres then joined Wyatt, who was doing most of the scoring, and took the score to 221 before Wyatt was caught, having batted in splendid style, his chief hits being 16 4's. Husbands and Bookless failed to stay long, both getting out by trying to hit, but Archer and Simms proved valuable partners to Morres. When stumps were pulled up the score was 410 for 6 wickets, Morres being not out 146.

The game was resumed at 11 o'clock on Thursday, Morres only adding 2 runs to his overnight score, when he was caught at mid-on, having batted very well; his chief hits were a 5 and 18 4's. Our last three batsmen were speedily dismissed, the innings closing at 12 o'clock for 448, giving us a lead of 230.

London started their second innings with the same batsmen, and runs came freely, 47 being made in half an hour, when Standish was bowled by Piper. The next four wickets fell quickly, Piper bowling Corry with a splendid ball, and Burgess being caught off a hard drive by Morres at mid-on. At lunch time the score was 100 for 5, and it looked as if we should win by an innings, but the remaining batsmen made a plucky effort and it was not until they had scored 292 that the last wicket fell at 4·30.

Wanting 61 to win, Barber and Simms went in and immediately started to score rapidly and in half an hour 54 runs were scored. Barber was then sent back by a good catch in the slips. This left us 7 to get, which were easily obtained, and at 5.30 we had won the match by 9 wickets. Scores :—

LONDON.

1st innings			2nd innings.	
W. T. Gibson, b Piper	27	b Wyatt	34	
F. Standish, c Barber, b Wyatt	19	b Piper	25	
R. Burgess, c Wells, b Piper	21	c Morres, b Piper	3	
H. B. Corry, b Piper	53	b Piper	4	
H. W. Kaye, c Simms, b Piper	12	b Davies	36	
C. E. Salt, run out	14	b Wyatt	42	
H. F. Noyes, c Wells, b Piper	1	b Davies	36	
C. T. Scott, b Wyatt	12	b Bookless	57	
J. H. Thomas, b Piper	14	b Piper	8	
J. Linnell, c Husbands, b Davies	22	c Archer, b Piper	24	
L. M. Waldron, not out	2	not out	9	
Extras	19	Extras	14	
Total	216	Total	292	

GUY'S.

H. Barber, c Corry, b Burgess	39	c Scott, b Burgess	27	
H. D. Wyatt, c Kaye, b Thomas	116			
R. Willan, c Salt, b Burgess	27	not out	2	
F. Morres, c Burgess, b Linnell	148			
F. A. Husbands, st Corry, b Linnell	11			
J. S. Bookless, st Corry, b Linnell	4			
H. Archer, c Noyes, b Waldron	37			
H. Simms, run out	39	not out	21	
S. M. Wells, b Linnell	0			
L. G. Davies, c & b Linnell	1			
L. A. Piper, not out	0			
Extras	26	Extras	11	
Total	448	Total (1 wkt)	61	

GUY'S 2ND XI. v. ST. THOMAS'S 2ND XI.

FINAL CUP TIE (JUNIOR).

This match was played at Hale End on Tuesday, July 19th. St. Thomas's batted first on a moderate wicket. They were all out before lunch for 99, 30 of which were byes. Leeming bowled well, taking five wickets for 41 runs. We started badly, losing Norton and Leeming for 10 runs, but Morres and Whelon altered the condition of the game, the latter taking an excellent century with only one chance when 80. Moyle and Miller played useful innings. In their second venture St. Thomas's made 138 for the loss of eight wickets, leaving us winners by 194 runs in the first innings. Scores :—

ST. THOMAS'S 2ND.

1st innings.			2nd innings.	
A. L. Barwick, c Rice, b Leeming	12	not out	12	
H. C. Devas, b Leeming	12	did not bat.		
B. T. Parsons Smith, run out	1	c Norton, b Morres	9	
F. B. Dalghish, b Rice	14	not out	54	
P. Harper, b Bartlett	4	b Allison	11	
E. L. Fyffe, c Iliffe, b Leeming	0	c and b Moyle	0	
W. D. Neck, b Leeming	7	b Leeming	11	
R. B. Abrahams, b Rice	2	b Morres	6	
P. Bennett, c Allison, b Rice	11	c and b Moyle	4	
O. Bruce, not out	6	b Moyle	7	
J. Clarke, b Leeming	0	b Morres	4	
Extras	30	Extras	20	
Total	99	Total (8 wkts)	138	

Guy's 2nd.

E. L. Norton, b Dalghish	4
A. Leeming, b Devas	6
A. Tubby, c Bruce, b Parsons Smith	35
E. Whelon, b Devas	102
G. Greening, b Parsons Smith	0
E. F. E. Allison, b Devas	3
H. H. Moyle, b Devas	52
W. H. Miller, b Barwick	35
O. G. Iliffe, c Devas, b Bruce	4
G. W. Bartlett, b Bruce	12
G. E. Rice, not out	21
Extras	19
Total	293

Batting and Bowling Averages.

Batting Averages 1st XI.

Names.	Innings.	Not out.	Best scores.	Total.	Aver.
H. Barber... ...	8	1	85	290	41·4
H. D. Wyatt ...	18	0	139	687	38·1
A. Archer	17	2	91	406	27·00
A. M. Tolhurst ...	11	0	102	291	26·4
H. Sims	16	2	67	361	25·7
R. Willan... ...	18	1	129	432	25·4
J. S. Bookless ...	19	0	64	332	17·5
F. A. Husbands ...	14	0	44	216	15·4
S. M. Wells ...	12	2	39*	134	11·1
S. A. Piper ...	9	3	20	51	8·6
L. G. Davies ...	11	2	35*	72	8·00

The following also played:—F. Morres, 12, 5*, 148; S. C. Bowle, 0, 10*, 8, 8; G. N. Bartlett, 0*, 2; E. Whelon, 0, 0, 8, 0, 10*; A. Leeming, 0*, 5, 0, 8.

Bowling.

Names.	Overs.	Mdns.	Wkts.	Runs.	Avge.
L. G. Davies ...	309	96	47	647	13·7
S. A. Piper ...	187	26	39	671	17·2
R. Willan ...	126	25	17	315	18·5
J. S. Bookless ...	67	12	10	193	19·3
H. D. Wyatt ...	366	68	54	1147	21·2
Following bowled in less than five innings:—					
G. N. Bartlett ...	38	11	11	82	7·4
S. C. Bowle ...	49	9	13	163	12·5

Matches played.	Won.	Drawn.	Lost.
18	6	4	8

Batting Averages 2nd XI.

Names.	Innings.	Not out.	Best scores.	Total.	Aver.
E. L. Norton ...	13	3	70	397	39·7
E. Whelon ...	5	—	102	183	36·6
A. Leeming ...	11	1	44*	265	26·5
G. N. Bartlett ...	11	5	34	142	23·6
T. R. Harvey ...	9	1	29	132	16·5
H. H. Carter ...	5	—	30	80	16·0
G. E. Rice ...	6	3	21*	46	15·3
O. G. Iliffe ...	6	1	24	79	15·8
H. H. Moyle ...	12	1	52	160	14·5
G. F. Allison ...	5	—	43	72	14·4
Also batted:—					
G. Greening ...	4	1	73*	108	36·0
J. L. Johnston ...	4	—	36	53	13·2

Bowling.

Names.	Overs.	Mdns.	Wkts.	Runs.	Avge.
G. N. Bartlett ...	158	35	39	504	12·9
G. Russell ...	47	5	11	153	13·9
G. E. Rice ...	71	8	18	258	14·3
A. Leeming ...	85	14	19	275	14·4
H. H. Moyle ...	74	9	18	292	16·2
Also bowled:—					
B. T. Verver ...	42	6	9	157	17·4

Guy's Hospital Lawn Tennis Club.

On Wednesday, July 13th, Blackheath beat us on their ground by seven events to two.

F. W. M. Palmer and H. C. Winckworth lost to Card and Dinwiddy, 3–6, 5–7; beat Relf and Plummer, 6–2, 6–4; beat Anderson and Rudd, 1–6, 6–2, 6–4. L. J. J. Orpen and H. C. Greene lost to Card and Dinwiddy, 1–6, 1–6; lost to Anderson and Rudd, 0–6, 2–6; lost to Relf and Plummer, 6–3, 4–6, 3–6. F. A. Barker and R. Davies-Colley lost to Card and Dinwiddy, 3–6, 2–6; lost to Relf and Plummer, 6–4, 3–6, 1–6; lost to Anderson and Rudd, 2–6, 4–6.

On Saturday, July 23rd, East Sheen "A" beat us by eight events to love.

Appointments.

Naval and Military.

Surgeon G. E. Duncan, R.N., is appointed to the *President* for a hospital course.

Captain C. E. Pollock, R.A.M.C., is promoted to be Major.

Lieutenant S. C. Bowle, R.A.M.C., from the Seconded List to be Lieutenant.

Edwyn G. Andrew, Esq., to be Surgeon-Lieutenant in the Royal Garrison Artillery (Volunteers) Duke of Cornwalls'.

Births.

DRAKE.—On August 15th, at 54, Old Elvet, Durham, the wife of G. Herbert Drake, L.D.S. Eng., of a daughter.

HARDENBERG.—On July 31st, at Duffield House, Watford, the wife of E. F. H. Hardenberg, M.B. Lond., M.R.C.S., L.R.C.P., of a daughter.

PRINCE.—On July 14th, at Reigate, the wife of Peregrine C. Prince, M.R.C.S., L.R.C.P., of a son.

TURNER.—On July 29th, the wife of Dr. G. A. Turner, M.O.H., Kimberley, C.C., of a son.

Marriage.

WACHER—PEEBLES.—On July 28th, at St. Alban's Church, Windlesham, Dr. Harold Wacher, of Canterbury, to Violet Amy, fourth daughter of the late Robert Davie Peebles, London and San Francisco Bank, and Mrs. Peebles, Fosters, Windlesham.

R. E.—Ed.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 426.] SEPTEMBER 10, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	353–355
Facial Paralysis complicating Middle Ear Disease. Clinical lecture by Mr. C. H. Fagge	356–362
Correspondence	362–363
How Roots got his Second Wife	363–365
Reviews	365–366
Testimonial to Dr. Eyre	366
From the Gazette's Special Pathologist ...	366
The Uses of Electricity and Light in Surgery	367–371
Papers by Guy's Men	371
Change of Address	372
Chapel News	372
Pupils' Physical Society	372

Passim.

THE first fruits of the long vacation are with us at last. The advance guard of distinguished physicians and surgeons has returned to a welcoming Hospital. How well they are looking! We do not grudge them their tanned complexions or their infinitesimal gains or losses in avoirdupois; to speak quite frankly, we regard them with a minimum of interest and only beg that they do not demand too much of those of us whose less fortunate lot it has been to be incarcerated in this charitable institution. It is a hard-eyed and unsympathetic garrison this of ours, let them not expect too much of us.

MEANWHILE the quidnuncs must possess their souls in patience for there is a lamentable dearth of topics of interest. We are told that a gold-fish has been seen in the park fountain, but must receive this rumour with a considerable amount of reserve. In all possibility the gold-fish is to the smaller journalism what the sea serpent is to the larger. One thing, however, must be chronicled, redounding as it does to the eternal credit of the Students' Club Committee. The board over the smoking-room mantelpiece has been removed! It is of course possible that the workmen who were for many days in possession of the smoking-room took it upon themselves to remove the eyesore, finding that it seriously hampered them in their work. But we prefer to believe that they were acting under orders, and if any remarks made in these columns, at any time, in any way helped to bring about so desirable an event, then indeed we are glad that "our weak words have struck but thus much show" of imagination from the Students' Club Committee.

APPARENTLY the opinions we expressed in our last issue, as to the best situation for a spring-board to be placed in the Swimming Bath, were shared by the authorities, for we hear that the board will soon be in position (if it is not so already) and will point towards the deep end in such a way that a running dive will be possible. There are curious rumours on foot, however, as to the probable efficiency of the proposed fixture, and we hear on good authority that two inches is likely to be the minimum thickness. The erection of a spring-board of such strength would be very much in the nature of a calculated insult, though at which section of the bathing community it would be levelled would be difficult to say. Certain it is that there is no one in the Hospital who could produce any impression on so unbending a spring-board, and if there were, it is an open question whether he or she could run through the gap in the wall from which the board will project.

FOR some time past there have been rumours of various changes soon to be brought about in the working of certain departments of the Hospital, and much speculation and discussion has arisen in consequence amongst those who will be most affected by the same. It will be obvious to all concerned, that the various interests involved make the appropriate settlement of these questions a matter of considerable difficulty; but, at the risk of being accused of indulging in platitudes, it may not be out of place to assert once more that in the nature of things the primary consideration at any hospital worthy the name is the welfare of the patients. Like many a moral axiom, this is sometimes in danger of being forgotten, and it would be as well to emphasize it once more as

being the chief standpoint from which all alterations in régime should be viewed. Again at a recent dinner in connection with Guy's one of the speakers spoke of the extent to which men at Guy's were placed in positions of trust and responsibility, and ventured the opinion that the affection of old Guy's men for their Hospital was due, in no small measure, to their gratitude for this confidence which had been placed in them towards the end of their student days and during their tenure of the various house appointments. These two considerations therefore—the welfare of the patients primarily, and secondarily, the endowment of those holding appointments with a reasonable amount of responsibility—may justly be said to have characterised the workings of the various departments in the past, and the innovations which will be introduced at the beginning of October will not only involve no departure from these traditions, but it is confidently expected will tend to enhance the first by a better ordering and systematising of the second.

STATISTICS show that the average number of patients seen in the Front Surgery between the hours of 9.30 a.m. and 6.30 p.m. is 250. The house-surgeon on duty is therefore compelled to see patients at the rate of 27 per hour, and on busy days, when the numbers amount to 300, at the rate of 33 per hour. This results in overcrowding, which is further complicated by the delay that takes place during the admission of medical cases by the house-physician. The better accommodation in the Women's Surgery will also tend to increase the number of patients and make the difficulty still greater.

THE first step that is to be taken towards coping with this overcrowding and delay is that the present two assistant house-surgeoncies in the Front Surgery and the two assistant house-physiciancies will be combined to form four appointments, all having the title of out-patient officer and all sharing the work equally. One couple will do the work now carried out by these assistant house-physicians for six weeks, and the work now carried out by the assistant house-surgeons for the succeeding six weeks, and vice versâ. Each of the four assistant surgeons' house-surgeons, except the one who is taking-in and is therefore on night duty, will be required to help the out-patient officer by taking charge of the Female Surgery for two mornings in each week from 11 till 1 o'clock. In addition to these alterations no case will receive treatment in the Front Surgery only, which can without risk of harm be drafted to its proper out-patient department.

UP to the present time there has often been considerable delay during the admission of medical cases by the house-physician. This is partly due to the fact that the latter is so much occupied with critical cases which have just been admitted to the wards that he is not able at once to obey the summons to the Surgery, and partly to the searching examination to which cases are submitted before admission. The new arrangement will be that the taking-in house-physician will be required to admit cases from the Front Surgery or Out-Patients' department into the wards of the three physicians, in rotation, to whom he is not attached, and not until the beds of those three physicians are full will he take cases into his own beds during his take-in week. The result of this arrangement will be that the taking-in house-physician will be able to answer the summons to the Surgery far more quickly than has hitherto been possible.

THE effect of these innovations will undoubtedly be to expedite matters in the Surgery, and such a result will be for the benefit of all concerned, of patients, officers and dressers alike. Nor will it be only in the Surgery that the effects of the coming alterations will be felt. It must be within the experience of all who have held the appointment of ward clerk in the medical wards, that during the take-in week the clerk is occupied in writing his reports against time, and the physician has so many new cases to teach upon that very often he is unable to deal fully with them all; also that during the week or fortnight preceding a medical take-in, the beds are largely full of chronic cases or cases that have passed the acute stage, so that the teaching on cases is at a low ebb. Under the new regulations cases will be coming

into the wards for three weeks in every month, report writing will not be so hurried and teaching will be continuous. Another consideration, that should not be lost sight of, is, that during the week in which a house-physician will be taking-in the nurses in his wards will be able to reckon on having a fairly quiet time.

It must be obvious to all that the general effect of these innovations in the prevention of unnecessary delays and the more even distribution of the work of the various departments will be for the benefit of both patients and officials alike, and while change is never a particularly welcome process, we have no doubt that the results will fully justify what, to some of the more biassed critics, may appear somewhat cataclysmic.

The October Dinner of the Students' Club will take place on October 3rd, at 7.30 p.m., in the dining-hall. Sir Thomas Stevenson, M.D., F.R.C.P., will occupy the chair, and the President of the Clubs' Union Council will be the Guest of the evening. Early application for tickets should be made as the number of seats is limited to one hundred.

In the *Contemporary Review* for this month will be found a most interesting article on "The Religion of the Errand Boy," from the pen of a present Guy's man who has had peculiar opportunities for forming the conclusions therein set forth with considerable insight. The paper is a sequel to a series which has appeared in this review on the "Religion of the Schoolboy," and, in the opinion of the writer, the errand boy does not by any means suffer by a comparison with his more fortunate brother. We read here of the errand boy:—

> "Sport occupies little of his attention until he has left school. School is at an end for him when he reaches fourteen. He has had little time for organised sport. An occasional game he may indulge in, but other matters occupy his attention. Sandwiched in between the school hours are intervals devoted to bringing in additional grist to the family mill. A paper round, a milk round, a house job are all considered to be legitimate means of filling up his spare time. His school time is occupied with mechanical parrot-like achievements, his working hours necessitate the expense of physical energy. The facultative powers of reason and of appreciation of higher things are as much drowned by these means in him, as the pursuits of the schoolboy permeate his whole life. The result of it all is vacuity."

Having come to the conclusion that both boys are practically negligible quantities intellectually, the writer makes his comparison directly.

> "The language of our boy (the errand boy) is more coarse . . . . . but I do not think he is more debased."

While many would be disposed to combat this conclusion, there are indications in this article that mercy seasons justice, and these lead us to accept this rather terrible verdict as the result of several years of thoughtful study.

> "I have seen a boy in real distress of mind about a failing, but had I desired with vulgar hands to tear away the veil that hid his thoughts, I had not succeeded. Trouble leaves its mark and makes him a man, while his Harrovian brother is yet a child; self-reliant, alert, and suspicious of a selfish world. But he will set his trust in a man who will treat him kindly, and, above all, justly. He wants no condescension or excessive affability—a quiet, calm, gentle reserve attracts him more than these.

The writer of this article would be the last to wish us to extol the virtue and the kindliness which led him to the study of his protégé, but we cannot help reflecting that if there were a few more to take such an intelligent and humane interest in "the poor folk," we should be a little nearer to the goal toward which mere charity and philanthropy are floundering in vain.

The ordinary hospital funny story is rather a miserable affair, having for its central idea such mistaken notions of medicine, physiology, or hospital routine as are perfectly comprehensible in a layman, and particularly in an uneducated layman. But we venture to narrate the following as a little more deserving of mirth with its irresistible blending of blarney, theology, and surgery. An out-patient at a neighbouring hospital having already roused the unfortunate dresser once in the small hours of the morning, owing to a black eye received in a drunken fight, applied again for treatment at about 6 o'clock on the same morning with the other eye in a similar condition, and the already injured one greatly improved upon. His assailant had a love of symmetry worthy of a better cause and had come for him again "loike a mannyiac."

> "What do you wake me up again for? I told you if he hit you again you were to come up after 9 o'clock or to go to Guy's. You're nearer to Guy's you know." "Guy's! not me guv'nor—gawd, oi've bin there once. Oi've the greatest respeck for —— —— Oi always come's 'ere. Me woife she come's ere too doctur. She's had two operashuns. Doctur —— 'e operated bofe toimes— an before 'e cut 'er the secind toime 'e says, 'Oi've dragged yer back from 'Eving once, 'e says, an' oi'll drag yer back agin, s'welp me,' an 'e done it too doctur!"

This is religio medici with a vengeance!

Facial Paralysis Complicating Middle Ear Disease.

CLINICAL LECTURE BY MR. C. H. FAGGE, July 11th, 1904.

GENTLEMEN,—In introducing my subject to you to-day, I want to show you two patients who have recently been operated on for the cure of middle ear suppuration complicated by facial paralysis of an infranuclear type. The first is a man aged 55, on whom the complete mastoid operation was performed on July 1st. You will notice he cannot shut his right eye, and the right side of his face is very expressionless: the naso-labial fold on that side is absent, and the whole face looks rather flat: you will notice there is no epiphora. On trying to shut his right eye he cannot bring the lids together, but the upper lid comes down a little, which suggests that the facial paralysis is not complete: as he makes this effort the superior rectus raises his eyeball so as to carry it under the upper lid, so that the cornea and retina may be sheltered from the light rays: this is done by over-stimulation of the third nerve, carrying the eyeball upwards. On trying to show his teeth he makes a peculiar mouth, for there is very little action of the right side, and he can also demonstrate that he has lost the power of his platysma on the right side. This condition was present some three weeks before he was operated on with the hope of curing the inflammatory process and so relieving the paralysis.

The second patient had had double middle-ear suppuration for twelve years. He is now 23, and when he came to out-patients he had had left facial paralysis for a week. He was admitted on June 8th, and operated upon the same day, a complete mastoid operation being done on the left side. The wound was skin-grafted on June 20th, and I made a note on July 5th at out-patients that the middle ear and antrum on the left side were dry: he is now having galvanism for the muscles on the left side of the face. When he was admitted his condition was much more extreme than the older man's, whose trouble was never more than a paresis, but you notice that when the young man's face is at rest, the muscles of the left side are pulled over to the right: as he smiles you notice that his naso-labial fold on the right side is very marked, but there is no crease on the left side, and he has all the other signs I pointed out in the first case.

In dealing with facial paralysis due to middle ear disease, I wanted to limit myself to local paralysis of the facial nerve in the tympanum which is always of the infranuclear type. It is clear that associated with middle ear suppuration complicated by cerebral abscess you might get a crossed facial paralysis, just as you get a crossed hemiplegia. This would be a facial paralysis probably associated with some paralysis of other parts on the opposite side of the body, due to a complication of middle ear suppuration, and would be of the supranuclear type and on the side opposite to the middle ear disease. In both the cases I have shown you, and in all the cases I shall talk about, the facial paralysis is on the same side as the middle ear disease. You can distinguish the supranuclear from the infranuclear type in two ways: firstly, in all the cases with facial paralysis, in which the facial nerve is invaded below its nucleus in the pons, the nerve shows electrical changes which I shall deal with in detail later, but in facial paralysis of the supranuclear type you get no reaction of degeneration at any stage. The second point is, that in supranuclear facial paralysis the muscles about the mouth alone are affected. In the men I have shown you the muscles about the eye and mouth, as well as the occipito-frontalis above, and the platysma below, are affected. In paralysis of the supranuclear type, all the muscles around the eye and those below the mouth escape, and the reason of the escape of the muscles around the eye probably is that they are not innervated from the cells of the seventh nerve nucleus, but from the nucleus of the sixth, where it lies near that of the seventh in the anterior half of the floor of the fourth ventricle and in the iter of Sylvius where these two nuclei are connected by a bundle of fibres which is called the posterior longitudinal bundle. Similarly, the posterior end of the seventh nerve nucleus is connected with the nucleus of the twelfth, which latter probably controls the muscles below the level of the mouth. So we see in our diagram that there are three nuclei—of the sixth, the seventh and the twelfth nerves, and fibres come out from all these and go to form the facial nerve. The upper ones go to the muscles of the forehead and eyelids, the next to the muscles of the cheek and around the mouth, and the third to the muscles below the mouth. It is clear that an infranuclear lesion would affect the mixed facial nerve, whereas in a supra-

nuclear lesion only those fibres actually derived from the facial nucleus would be affected.

But I want further, on account of the short time at my disposal, to limit myself to intra-tympanic paralysis, and propose to say nothing about the causation and treatment of facial paralysis when the nerve is attacked, as it may be, between its exit from the pons in its passage through the meninges to the temporal bone, even though this type would be infranuclear and would give exactly the same evidences as are seen in the cases I show you.

I should like to suggest that a slight degree of facial paralysis is more common as a complication of middle ear disease, or as a sequela of intra-tympanic operations than is generally supposed, for it is easily missed, and sometimes is quite transitory, disappearing after being slightly in evidence for a few days. I feel sure I have missed its onset on several occasions, so I want you always to think of and be on the look out for it, for it may be the first indication of graver disease than other signs had led you to suspect.

So let us pass on to review the signs of infranuclear facial paralysis to be seen in affection of the nerve within the tympanum, most of which I have been able to demonstrate in the two patients seen to-day.

The first indication is loss of tone in the muscles of the affected side of the face, giving rise to a loss of expression in repose when that side of the face appears unusually flat, sometimes the angle of the mouth drops, and if the paralysis is extreme, as in the younger man we saw to-day, the face is drawn by the normal muscular tone to the unaffected side, so that even when at rest the face has an odd and asymmetrical look. The way in which it is so drawn out may cause some confusion, because if you tell the patient to protrude his tongue, it is apparently out of the straight line: this is not, however, due to any fault in the tongue, but to the fact that the middle line of the face is no longer median. I might have demonstrated this point in the younger man, for it was noted at the Electrical department that the tongue is protruded to the paralysed side, because the face is drawn over to the normal side, and the notes go on to say that there is no evidence at all of hypoglossal paralysis. Patients with this form of facial paralysis lose their reflex winking or blinking; so that they blink involuntarily with one eye only.

In an extreme and chronic case you find epiphora; most of my cases had not epiphora, but in a pretty little girl whom I had hoped to show you to-day, one of the most distressing symptoms was epiphora: hers was a chronic case of post-operative facial paralysis.

Neither of the patients you saw could smile or show his teeth, or whistle, or wrinkle the forehead, either vertically, by the corrugator supercilii, or horizontally, by the two parts of the occipito-frontalis, and these patients cannot sniff, for if they try you would see that the ala of the nose on the good side would act, but on the other side it would remain motionless. Usually when any of these acts are attempted you get a great distortion of the face; for if the little girl of whom I spoke smiles, she makes the worst face imaginable.

One of the worst troubles besides epiphora is the fact that owing to the paralysis of the buccinator the food collects between the cheeks and the teeth: until the patient has got used to this, and has learned to clear this food away with the tongue or finger, it is a source of great inconvenience to him.

Some observers record loss of taste to sweet and bitter substances on the anterior half of the side of the tongue from destruction of the chorda tympanic, but in those of my cases in which we have looked for this we have never satisfied ourselves that there was loss of taste.

Finally, bear in mind that in children the elasticity of the facial muscles is well marked, much more so than in adults, so that a slight degree of paralysis is in early life more difficult to detect, or incomplete recovery may be quite hidden unless very carefully looked for.

The causes of this type of facial paralysis are mainly founded on an anatomical basis, and so I may be excused for drawing your attention to some anatomical points in connection with the facial nerve.

As you examine the temporal bones which have been passed round, you will notice that in the tympanum the facial nerve lies in a thin-walled bony canal, above the promontory on its inner wall, and so passes backwards curving above and then behind the foramen ovale, in which the base of the stapes is fixed, to lie on the inner wall of the aditus or passage between the antrum and attic, where it leaves its thin bony canal and becoming cased in the thick bony shell of the mastoid process, passes on its deep aspect downwards, but also slightly outwards and forwards to the stylomastoid foramen.

For a moment pay attention to its surroundings as it lies in its bony canal at the most anterior part of the inner wall of the aditus, for it is here that it is most often wounded operatively, notice that it is passing in a frail

canal for a short interval from compact bone above to compact bone below; notice that the outer wall of the aditus is the bridge of hard bone between the antrum and tympanum which has to be removed in the complete mastoid operation; and lastly notice that the foramen ovale and stapes lie below and in front of this canal and the horizontal semi-circular canal above and behind it at this point. I hope you can now verify all these points for yourselves.

A propos of this, I would commend to your notice some anatomical guides to the facial nerve, which a Guy's man, Dr Hugh Jones (*vide* Otolog. Soc. Trans., vol. iv., p. 99), of Liverpool, has introduced. I have not time to go into them fully now, but the main point that he makes is this: that a line drawn from the inner wall of the aditus to the highest point of the floor of the external auditory meatus will keep well outside the facial nerve. I have passed round temporal bones which are cut into two halves, and you will find that an attempt has been made to bisect these bones in an axis passing in the sagittal plane obliquely downwards and outwards, which above reaches the inner wall of the auditus, and below cuts the highest point of the external auditory meatus. In every case in which this has been done the facial canal is on the inner half of the bone, and as all the bony parts we ought to remove in our mastoid operations are on the outward half of the bone, if we are guided by Dr. Jones' line, we should do the nerve no harm.

Many exact measurements have been done in connection with the facial nerve, and an interesting paper on this subject was read before the Otological Congress in London in 1899, and the conclusion one comes to is rather a sad one, because the facial nerve is a thing which never varies to any measurable extent, and if you do touch it you cannot say it was in an abnormal position. If you injure it, it is due either to the fact that it is exposed through a congenital or pathological gap in its walls, or that you remove its normal walls.

In the matter of causation, I do not know that there is any recognised division of cases, but the cases which have come under my care were associated with the following causes:—

a.	Catarrhal otitis media	1
b.	Acute suppuration	1
c.	Chronic suppuration	5
d.	" " (tuberculous) ...	2
e.	Growth	1
f.	Traumatic	1
g.	Post-operative	7

a. One of the first cases I took into the wards was a child, a girl æt. 14, who had attended the out-patients for some months for middle ear catarrh. In April, 1903, she had a cold, and the deafness increased, though the tympanic membrane showed only slight inflammatory changes. There was little pain, but complete left facial paralysis of the infranuclear type. She was admitted for treatment, and the pain relieved by blisters over the mastoid, and the use of Politzer's bag. Under these measures and galvanism the facial paralysis had in two months entirely disappeared. I mention that case because there is no doubt she had an ordinary middle ear catarrh, simple stuffiness in the head, with slight pain and unpleasant sensations in the ear rather that acute pain. It seems to me that this case might suggest the real causation of those cases of facial paralysis sometimes called rheumatic, which are said to follow a cold or a draught, for possibly they may be slight cases of middle ear catarrh, in which the catarrh was not associated with much pain and was not paid attention to, and which naturally got well before the facial paralysis.

(To-day, September 6th, a similar case came to Out-patients' with a three weeks' history of cold and deafness and three days' paralysis: the child was Politzerised and blistered, and galvanism ordered: a good prognosis was given.)

b. The next is a case of acute suppuration. The patient came to me in March of last year with acute pain in the ear, which commenced on March 22nd, and had been treated by opium instillations. On March 23rd, when I saw him, he had practically no hearing power in the right ear, and his tympanic membrane was acutely injected. Next day there was more pain, with right facial paralysis, and a temperature of 102·6°, so on the 25th I opened his membrane, and was rather surprised to evacuate pus, for I did not think, from the appearance of his membrane, which did not bulge markedly, that the process was so acute. On examining the pus, we found it contained a pure culture of pneumococci. Under antiseptic treatment, at the end of three weeks all his discharge had ceased, and in about seven weeks his hearing was normal: in two to three months, under galvanism, his facial paralysis had disappeared. Some of you may know the patient and will be able to verify the truth of this.

Here was a man who, for some reason, had his facial nerve attacked in an acute suppurative otitis media. I think the case was unusual, and I suppose that the inflammation either spread through the foramina, from which branches of

the facial nerve reach the tympanic cavity, or that he had a congenital gap in the bony wall of the canal of his facial nerve.

c and *d*. The next seven cases were like those of the two men you saw, facial paralysis coming on in chronic suppuration, two of them being tuberculous.

One of the temporal bones passed round shows the facial nerve exposed to a very large extent as it goes through the temporal bone of a child in whom facial paralysis came on suddenly in the course of chronic suppuration, with much swelling of the infra-auricular glands; which two things should make one think of tuberculosis. I had done a complete mastoid operation on that child some nine months before the facial paralysis came on; her facial paralysis was followed by an enlargement of these glands, rapid emaciation, and later by convulsions, and death. Cultivations both from the ear at the second operation, and at the autopsy, showed multiple evidences of tuberculosis.

The second case of tubercle is this one, of which I show you a sequestrum of the whole of the petrous portion of the temporal bone in a child.

In both these cases due to chronic tuberculous suppuration, the paralysis was complete, and I think would have been permanent.

The other five cases are those of facial paralysis coming on in the course of middle ear suppuration, usually due to infection by cocci. Of these, three who have been operated upon long enough to draw any conclusions from, have entirely recovered, and the two last you have seen to-day, but they have been done only a few weeks. From these cases I want to point out that you can usually cure facial paralysis if it comes on in the course of chronic middle ear suppuration, by removing the suppurative focus. If you will clear out the antrum and middle ear, and skin-graft the cavity, I think the facial paralysis will get well with the aid of a little galvanism. The following cases illustrate my point:—

I operated on a woman in October, 1901, who had had otorrhœa for sixteen years and facial paralysis for several weeks. In January, 1902, the facial paralysis had disappeared, except in one particular, namely, that the frontalis on that side was and is still weak.

We occasionally see a man at Out-patients who had a complete mastoid done in June, 1903, for sixteen years' otorrhœa, and six weeks' facial paralysis, and in September the paralysis was unnoticeable. The third case was a girl who was admitted in November, 1903, with chronic suppuration and facial paralysis. A complete mastoid was done and the paralysis was cured in about three months.

As a rule the paralysis is not cured by the time the operation cavity is healed, so I do not expect much improvement in the two men I showed you for the next few weeks, for the younger man was operated upon on June 20th, and the elder man ten days ago.

e. We now come to the fourth heading, facial paralysis due to growth. Some of you may have seen at Out-patients, in March, a woman, æt. 79, who had a very large polypus in her external auditory meatus. She said she had had severe pain with otorrhœa for about two months and had noticed a lump in the ear for six weeks; she also said she had had facial paralysis for at least two weeks. The two men I showed you averaged fifteen years of chronic middle ear suppuration before facial paralysis came on, so the old lady of seventy-nine, with facial paralysis a month after the onset of suppuration, did not seem to be a simple case, for if facial paralysis comes on early in middle ear suppuration in a child it generally means tuberculosis, and if you get it in an old person it may mean malignant disease. I think I have only seen four such cases myself, and they were at the Otological Society meeting, where, of course, the rare cases are collected, for the case I mentioned is the first case of growth of the tympanum I have seen in five years and a half at the Out-patient department here. There was a large pedunculated mass which had burst through the drum and projected from the meatus, and one of the dressers cut a piece off for examination, when it was found to be a typical epithelioma. There was also a mass in her neck, which was evidently due to the extension of the growth, and made it clear that no operation could be done for her. We were about to admit her into the ward, but she went into an infirmary and died the next day, after a very painful illness of not more than three months.

f. The next case is one of traumatic division of the facial nerve, which is not usually intra-tympanic. The condyle of this man's lower jaw, much of the temporal bone and the facial nerve, and most of the structures in that region were carried away by a bullet in the South African war, when he was treated by Sir Alfred Fripp, who sent him to me. I think there is no doubt that the facial nerve was injured in the middle ear, and not in the parotid gland. It has never been thought advisable to do anything to his

middle ear, which is dry and closed up, or to his facial nerve.

g. The last class of cases is composed of post-operative paralyses. As far as I can find out, I have had ninety-eight cases of chronic suppuration necessitating a complete mastoid operation, or acute mischief with extensive operation under my care. I am not including acute cases in which the antrum alone is opened, because it is clear that if it is necessary only to do this to satisfactorily deal with the focus of suppuration, you should not get anywhere near the facial nerve. Of the chronic cases I have operated upon, or of the acute cases in which there was a chance of going near the facial nerve because of the extensive disease, making ninety-eight in all, I have had seven cases of facial paralysis.

The first was a child three years of age whose facial paralysis immediately followed the removal of an extensive necrotic area of bone, and the evacuation of an immense extradural abscess. Six days later a cerebellar abscess was evacuated, but she died of cerebritis six weeks afterwards. Here I think one was justified in dividing her facial nerve, because I operated extensively, attempting to prolong life if possible, and the preservation of the facial nerve must then be of secondary importance, for in this case, I think, it would have been impossible to remove the sequestrum and expose the limits of the extradural abscess without destroying the facial nerve.

In the second case, a child æt. 4, the paralysis came on a few hours after the complete mastoid operation. Five months later a large piece of the cochlea sequestrated, and I was surprised later to find that her facial paralysis was improving, because I thought there must be extensive disease of the labyrinthine wall. I have not seen the child for something like three years, but when I saw her about a year after the operation she was almost well.

The third was a case of paralysis twenty-four hours after the complete mastoid operation, on a girl æt. 8, and she was well in two months. She was operated on by me at the Evelina Hospital, and her face twitched at the operation.

The fourth was a boy æt. 3, at the Evelina, in whom facial paralysis was noticed the day after operation for a large subperiosteal mastoid abscess extending down into the neck, complicated by an extradural abscess. I have little doubt that in this child, when evacuating the large abscess in his neck, which extended to the angle of the jaw, I had stretched or scraped, or in some way injured the facial nerve, after it had emerged from the stylo-mastoid foramen. The operation took place in March, 1902, and the paralysis was well in two months. I have seen him recently and he is quite well.

The above four cases were all children, in whom we should bear in mind that as the mastoid process is yet undeveloped, there is a special danger that even by the preliminary incision for opening the antrum, the facial nerve may be injured, because it comes out upon the external rather than upon the inferior surface of the bone.

The first case I took into the wards when I was allotted beds, had facial paralysis two days after the complete mastoid operation: this was done in April, 1903, and in June she was much improved. I am glad to say that long ago she became perfectly well.

My sixth case was that of a woman who was suffering from secondary syphilis. In May last year a radical mastoid operation was performed, it was the most sanguinary operation I have ever performed on the mastoid, which may have been due to the syphilis. Facial paralysis followed in twenty-four hours, and it had entirely cleared up within four months of her discharge.

The seventh and last case was an interesting one. W. W. had a radical mastoid operation performed in February of this year, and slight facial paralysis was noticed on the third day after the operation, but it was entirely unnoticeable on the tenth day after operating. As I have said, if you observe your cases closely you will observe facial paralysis more often than you expect, and here the observation was entirely due to the keenness of his dresser.

The first two of these seven cases were probably due to direct injury to the nerve; and my reason for saying this is the immediate onset after the operation, for if the paralysis comes on immediately the patient comes round from the anæsthetic you may be almost sure you have done some extreme harm to the facial nerve. The fourth case was probably injured outside the stylo-mastoid foramen, and should not really be included in my list. In the first case I think I was justified in injuring the nerve, and in the others paralysis was probably due to secondary inflammation coming on twenty-four to forty-eight hours after operation, or to pressure by blood-clot; the possibility of the latter being the cause of paralysis is interesting because, except for my seventh case, I have had no case of paralysis in the last fifteen months, and since February I have scarcely ever plugged the cavity after a complete operation, for it seems to me that if you fill up the cavity

with a plug you are especially liable to cause a dangerous pressure which may affect the facial nerve. So I am inclined to think some of these cases of facial paralysis might have been avoided if the cavities had not been plugged.

I have given you a full list of my misfortunes and have ultimately been fortunate, for in only one was the paralysis complete or likely to be permanent, and this case (No. 1) died of intracranial mischief. But even though the cases I have related to you recovered, yet occasionally the following questions must be asked:—

If cases do not get well what should you do? Facial paralysis after operative or other traumatic paralysis usually begins to get well within about six weeks, and often earlier.

The indications for further operative treatment would be: loss of tone in the facial muscles: reaction of degeneration, *i.e.*, diminished reaction of the nerve to faradism and to galvanism; loss of faradic excitability of the muscle, and increased excitability to the constant or galvanic current, and polar changes with this current, in which A.C.C. = or (= is greater than) K.C.C.

How long should you wait before doing anything? It seems probable that if a facial paralysis persists for six months after operation, it will not get well by itself, or by galvanism.

I intended, had time allowed, to have dealt fully with this part of my lecture, and to have discussed the operative cure of facial paralysis by suture of the distal end of the seventh nerve to some other cranial nerve.

This method of treatment, and in fact the whole question of operative treatment of paralysed nerves is closely bound up with the theories of nerve regeneration, for you will remember that the established theory pronounces that a motor nerve regenerates from its central end by a new downgrowth of axis cylinder processes towards the paralysed muscle, the distal degenerated portion merely acting as a kind of splint or guide to the newly growing axon. The newer theory, which is well enunciated by Ballance and Stewart (Healing of Nerves, 1901) is that regeneration takes place in the distal end, even when separated from the central end, and accepting the probable truth of this surgeons have grafted the distal end of a degenerated motor nerve into another healthy motor nerve.

Dealing only with this question as it applies to the facial, I may just review a few of the chief incidents and advances in the operations. The first was Ballance's suture of the facial to the spinal accessory in 1895, and in 1898, Faure (Traitment Chir. de Paralysie Faciale. Congrés de Chirurgie, 1898) united the seventh to the trapezius branch of the eleventh after its division. Körte (Deutsche Med. Wochenschrift) united the seventh to the hypoglossal in 1902, and Ballance records in the Brit. Med. Journ., May 2nd v., 1903, how he united the seventh to the side of the hypoglossal. Here he, in an excellent review of both the pathological and surgical aspect of the whole question, decides that this ought to be the best method, partly because it necessitates no division of another nerve and therefore no paralysis of other muscles, and mainly because the cortical motor areas of the face (vii.) and tongue (xii.) are nearer together than that of the shoulder (xi.) and face (vii.), and so less education of the cortex is necessary.

The ideal method is one of grafting the distal end of the divided facial into a notch in the nerve sheath of the hypoglossal, just where the latter artery, embracing the ganglion of the trunk of the vagus, passes outwards between the internal carotid and the internal jugular vein.

Three cases of permanent facial paralysis have come under my notice.

A.S., had a mastoid operation in 1902, after which he has the usual signs of facial paralysis and his facial muscles did not react to either galvanism or faradism. In May, 1903, I removed a large number of tuberculous glands in order to reach the hypoglossal nerve; the mastoid process was freely removed, and the facial dissected up a little way within the bony canal, when it was cut and the distal end sewn into a notch in the hypoglossal sheath, as this was being done the facial unfortunately broke, about a quarter of an inch being torn away from the distal end: it was now found to be too short to reach without tension the hypoglossal, which had been carefully raised from its deep situation, so the originally intended anastomosis was given up, and the distal end of the seventh was grafted into the notched sheath of the undivided spinal accessory.

Slight hypoglossal palsy followed its manipulation, but the report notes that the tongue is protruded normally on June 10th: further it is noted that the tone of the facial muscles soon improved, but when last seen there was but little improvement in the paralysis. The sterno-mastoid and trapezius were unaffected.

M. K., the little girl I spoke of earlier, had complete left facial paralysis after a mastoid operation about Christmas, 1902. As under galvanism it did not improve and R. D. was marked, I completed the radical mastoid in September,

1903, and carried out the facio-hypoglossal anastomosis (end to side as suggested by Ballance), the muscular tone soon improved, and the movements of the muscles around the eye are now quite perfect, but the position in repose and the movements of the angle of the mouth are still very bad.

(September 1st, 1904. The child was seen to-day and smiles almost symmetrically, while at rest no deformity is detectable, the naso-labial fold being as well marked as that on the opposite side).

In a third case, C. C., æt. 20, permanent complete facial paralysis followed an ear disease in infancy, galvanism was useless, but as Dr. Bryant reported that the facial muscles react neither to faradism nor galvanism, I decided that operative interference could do no good. This last case partly answers my last question.

Is there any period beyond which it is useless to do anything? It seems to be true that unless the muscles of the face react to galvanism, such an operation as was carried out in the cases quoted above is useless, but in giving this definite opinion, and in condemning this last girl to a permanent and hideous deformity I must ask you to bear in mind that on this, as on several other points of which I have spoken I am voicing opinions (perhaps immature) of authors who, like myself, as yet have had no opportunity for an extensive experience in what is really comparatively a new field.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Letter from Dr. Eyre.

SIR,—May I, through the medium of your columns, express my very sincere thanks to the many friends who have given practical shape to their sympathies and have relieved me of the costs incurred in my recent action against the Scottish Accident Company.

I would also like to take this opportunity of marking my deep appreciation of the sentiments contained in the letters on the subject received by both Dr. Bryant and myself—letters so numerous as to render it impossible for me to reply to each individually.—I am, sir, yours faithfully, JNO. EYRE.

Bacteriological Laboratories,
Guy's Hospital, S.E., August 18th, 1904.

Movable Kidney.

SIR,—There was a custom in my time at Guy's for those who were either anxious to learn more, or wished to appear to be so, to descend at the close of a lecture and interrogate the lecturer—a performance often rather disheartening to the latter.

Those who give clinical lectures at the hospital must remember the large audience (if the word is permissible) outside the doors of the theatre, which regards these lectures as the most reliable and useful of current medical literature, far exceeding in value the columns of unscientific theorisings and vapourings which editors of repute allow to be published.

I would urge on you, sir, if it be necessary, the great importance of continuing your present custom of giving us at least one good clinical "talk" per issue, and I would ask the lecturers to choose subjects of every-day importance, and not to dwell on the rare and the weird.

The average G.P. never sees a case of acute pancreatitis but he sees many movable kidneys, and I should like to thank Mr. Golding-Bird for choosing such an important ailment as this for his theme.

At the same time I would beg him to grant me the privilege enjoyed by those who listened to his lecture of descending from my distant bench and putting some questions to him.

(I would here mention that I have not read the previous lecture Mr. Golding-Bird refers to in the one published in the GAZETTE for July 2nd, in which he apparently discussed the anatomy of the kidney's anchorage. Did it appear in the GAZETTE?).

Mr. Golding-Bird gives a case of a kidney displaced by a sudden strain, but like the Russian admiral's report, he is silent just when one is getting interested.

By what mechanical means can a sudden strain, apart from any direct blow, displace a left kidney? A hæmorrhage round the kidney would loosen its connection, but such an accident, apart from a blow, would be very unusual. I could conceive as possible that a violent contraction of the diaphragm accompanying a powerful muscular effort would displace a right kidney by forcing down the liver, but I should have thought that powerful contractions of the diaphragm and anterior abdominal muscles would merely hold a normal left kidney more firmly in its bed.

Is it not possible that the loss of weight in this patient was the earliest symptom of a condition of which the movable kidney was but another, and that the muscular strain nipped it when it was out of place and started in it a pain such as follows an injudicious bite on a decayed tooth? The pain following the bite continues and drives the sufferer to a dentist, but the tooth had been decayed for some time previously. Again, if sudden strain can displace a kidney, why is not the condition commoner in men? I have never seen a case in a man, while I have seen a great many in women.

Mr. Golding-Bird omits to give us the result of the nephrorrhaphy in this case, although for such information to be of value, at least twelve months should elapse before a definite conclusion can be arrived at. It would be highly interesting if some statistics of this operation were given. If they exist I have not seen them. The results of fifty cases seen twelve months after operation would, I venture to suggest, give one cause to think seriously.

I remember, when at Guy's, seeing many cases on the medical side no better for an operation; the pain might have left the kidney, but only to seize on some other abdominal region for its base. Surgeons may call these cases cured, but the physicians and the patients hold another opinion.

Mr. Golding-Bird says, "The treatment of ptosed kidney is now well agreed upon." Does he mean that when there is pain it should be fastened down?

May I quote a physician of very wide experience on this point? In his "Common Neuroses," Dr. Goodhart says of movable kidney:—"All I wish to convey is that the patients are neuralgics, and that to be a neuralgic indicates a vice of nervous action that an operation can seldom hope to cure, and that since we are thus only treating a symptom, in no sense attacking the disease, these are cases for great deliberation." Mr. Golding-Bird says that "unless associated with a general splanchnoptosis the operative results are most satisfactory."

Dr. Goodhart quotes a case of his operated on with apparent success, and says of it: "I came, therefore, to the conclusion that I was wrong, and that fixing the kidney was after all a successful operation. But time has gone on, and now I hear that the pain still occasionally recurs."

How is it that a physician and a surgeon, both of great experience, differ so radically in their conclusions?

Mr. Golding-Bird refers to the historic case in which Mr. Durham removed the kidney, and as he rightly says: "The interest in her case was very great." That case is still of great interest apart from its being the first nephrectomy done in this country, for a reason that Mr. Golding-Bird does not mention. The most careful examination after the patient's death revealed no disease either in the removed kidney or in any organ of the body. Such a case is not unique, but it serves well to show us that we do not know everything about the kidney after all, and I am of opinion that we really know very little about movable kidney except that it is a very common complaint, and may give rise to no symptoms or may convert a healthy woman into a chronic invalid.

Mr. Golding-Bird says that he recently had to remove from a young woman a kidney that the late Mr. Davies-Colley had sewn down some years previously. What were the symptoms necessitating this further operation, which I suppose was done on the living?

If I have appeared to question Mr. Golding-Bird's teaching, it is only from a serious desire to know something about the treatment of this common and troublesome complaint. I have no wish to air views for notoriety's sake, nor do I feel that I have a message to send forth; hence I write anonymously. It is very tiresome to be met day after day with the remark, "I am afraid, doctor, I don't get any better"; on the other hand, it is unsatisfactory when you have put the patient to the expense and anxiety of an operation, to find her as bad as ever. And if she suppurate, or possibly die?—I am, etc.

"THOMAS."

How Roots got his Second Wife.

"ROOTS," said I, "you have rather a confused family." This remark was extracted from me when I stumbled over little Bobby Roots, aged two, in the hall, and nearly fell into the arms of Miss Lizzie Roots, aged twenty-two, a tall and buxom lass.

"Well, you see, sir, I've 'ad two of 'em."

"Two of what?" I enquired, puzzled.

"Why two missuses, of course."

Having deposited four tablets and administered some valuable advice from my professional store to Mrs. Roots No. 2, I descended the stairs and met Roots, who was plainly full up to the brim with a story.

Now Roots was a sturdy, honest, grey-haired yeoman, famous far and wide for his yarns.

"Perhaps you'd like to know how I came by my second wife."

As it seemed to me well worth half-an-hour and a couple of cigars, I sat me down, pulled out my cigar case, drew my chair up to the fire, and presenting the case to Roots, said, "Have a smoke, and go ahead with the story."

"Well, sir, when No. 1 was alive—and a cheerful one she was, although I must say she had a tongue—No. 2 used to come up here pretty nigh every afternoon for a gossip. What them women find to talk of day after day beats me, sir, but 'igh and low they all does it. When I was coachman to Lady Betsy up at The 'Ouse, I'd take her and another fine lady out for a drive, and they'd chatter for two nurchul 'ours and never draw a breath. Their 'ats, their stockin's, their 'usbands and their wicked ways, their kids—till you'd think they'd be 'oarse, but bless you, sir, a woman's voice-box ain't built the same as a man's. But there that's a digression, and perhaps I'm keepin' you from your patients."

I hadn't any other patients but I tried to look busy and nodded to him to go on.

"Well, sir, No. 1 got the new-monier, and the doctor said he'd pull 'er through. He brought about a 'underd weight of ice and stuck bits of it all over her chest, w'er'iver 'e 'eard what he called a rawl—'e seemed to be chasing that bloomin' rawl day and night with lumps of ice—I must say 'e was the most perserverin' young gent I ever seed. Then 'e brought a big iron bottle in his cart, and pulled out the cork with a piano-tuning key. 'E says, sharp like, 'Old that,'—a sort of tun dish it was, with a tube—'to your wife's nose.' I

suppose he pulled the cork too quick because 'e nearly blew the missus out of bed. Then 'e began a shoving with the tuning key and swearing, and the sweat rolling off 'im, and all the time the wind was a roarin' out of the tun dish, and just when he'd managed to cork it up again 'e says, 'Blessed if there ain't five bob's worth of hoxgan wasted.' Then the missus guv a choke and died, which put a end to the conversation for the time being. 'E was a clever young gent, and very kind-'earted; they said as 'ow he'd walked all the 'ospitals in London—but what I blames 'im for is that he'd never let the folks die quiet and respectable like in their beds—same as you do, sir. Well, the doctor was very down-'earted, and I says to cheer 'im, says I, 'You done your best and no man can't do no more; it's Nature and not you,' says I, 'what killed her. What was to be, was to be, and I'll see you gets your money.' Then 'e left the 'ouse without a word, lookin' very sad, and as he got into 'is cart he says, 'Roots, it's very disappointin'.' I can't say I was disappointed because I knew from the first she was going to 'op it. Then I sat down lonesome and miserable."

"What about your second wife?" I here interjected.

"'Old on, I'm comin' to it. You must let a man tell 'is story 'is own way," he replied. "Well, Martha, that's No. 2, sir, she come to the funeral all black and a handkercher with a black border, so that you couldn't scarcely see no white. Martha was mighty sympathetic, always was. About a month after, I was feelin' very down-'earted like, the 'ome was wretched and the children always a cryin', when who should I meet but Martha. 'Ow are you?' says she. 'Chippy,' says I. She was a fine figure of a woman then, sir, though you mightn't think it to look at 'er now. 'What's done can't be undone,' she says, and she taps me on the shoulder. 'Cheer up, old chap,' she says, 'I'll be your No. 2.' After that we passed the time of day and I went 'ome. Martha was mighty good to the kids, generally about twelve o'clock when I come in to dinner. It may 'ave been six weeks after that I went to my club. The Buffaloes was sympathetic, perhaps a bit too sympathetic, and I don't mind confessin' it I 'ad a drop too much. When who should I chaunce to meet in the road but Martha. She was lookin' ravishin', and I felt my 'eart goin' out of me, and before almost I knew what I was sayin', I says, 'Martha, do you remember what you said a bit back? Did you mean it?' 'Go along,' says she, 'I don't know what you're talking about.' She did know, sir, I seed it in her eye. No woman can't manage her eyes, they mostly always give 'er away. I daresay you've noticed it, bein' a doctor."

I nodded sagely, Roots took a long pull at his cigar, and proceeded.

"Well, if you did, Martha, we'd better settle it once and for all, 'ere and now.' You see, sir, I wasn't quite myself so to speak. I tried to catch hold of 'er, but she fairly jumped into the road and I sot down rather sudden on the kerb. 'Mr. Roots,' says she, 'aughty-like, 'I'll sleep on it and let you know to-morrer at eight o'clock 'ere.' When I got up and 'ad dusted myself she was gone. My 'ead fairly ached next day."

I smiled.

"No, it wasn't that, sir; it was thinking of eight o'clock. About arf past seven I was there togged out and talking to the policeman at the corner, when 'oo should we see acomin' a long the road very slow but Martha. 'Constable,' says I, 'lend us your 'and-cuffs.' 'It's strict against the regulations,' 'e says. 'Never mind,' says I, 'I ain't so fond of the bracelets that I'm going to run away with 'em.' Presently Martha comes up, and lookin' at me as if I was the last man she ever expected to meet. Wonderful is the ways of women! She says, 'Allo, you 'ere!' I've thought since it was play actin' for the benefit of the policeman. I shook hands with her, and slips one of the 'and-cuffs on her wrist before she knew what I was at. There we was fixed together like 'let no man put asunder.' I can tell you it was lucky for me, sir, it was 'er right arm or she'd 'ave killed me. Women is akward with their lefts. She called me all the names that she could think of, and the policeman laughed until the fire bell rang, when 'e ran away and left us fixed together, 'e 'avin' forgot the bracelets, and I didn't know the secret. By-and-by, Martha calmed down a bit, and I said 'It was only a bit of fun,' and kissed 'er 'and. That seemed to bring her round quicker nor anything. Perhaps you have tried that treatment with contrary women," he said with a chuckle.

I looked severe and professional.

"To make a long story short, we was soon agreed to splice, and walked very lovingly arm in arm. Lor' love you, we couldn't help it."

He laughed so long at the recollection that I thought the story would never be ended. At length, being more composed, he continued.

"I took her to the police-station, and when the Superintendent 'ad pulled 'isself together,

after falling off his stool a laughin', 'e let us loose after givin' us 'is blessin'. And that, sir, is 'ow I got No. 2, and it accounts for them kids in the 'all."

"Good day, Roots. Have another?"

"Well, I don't mind if I do, sir."

"PEN."

Reviews.

The price of books submitted for review should in every case be stated.

Les Fractures de l'Humerus et du Fémur. Par Théodore Kocher, 284 pp. (Alcan, Paris). 15 francs.

This is a French translation of a work by the celebrated surgeon of Berne, and, though possessing the above title, it actually only describes fractures of the upper and lower end of the humerus, and of the upper end of the femur—the rest, doubtless, being reserved for another volume, though no mention is made thereof. The book, though characterised by the usual want of binding—common to French books—is well printed and excellently illustrated by a large number of wood-cuts and photographs; the former are mostly diagrammatic, showing the condition of the bone *as diagnosed* in the various cases, but the latter illustrate very well the various positions assumed by the damaged limb, after the various fractures have taken place. It seems strange that a book should be published now on fractures without a single skiagraph being reproduced, yet such is here the case; nor can we find any mention of X-ray photography as an aid to diagnosis, the explanation being that most of the cases were recorded before 1894.

We have descriptions of a large series of cases observed by the author himself and recorded with a wealth of detail, which is especially noticeable in those cases that came to an autopsy, the exact state of *all* the organs after death being minutely described. The prognosis of each variety of fracture is very fully discussed, and the effects of treatment thereon. Dr. Kocher seems to especially favour extension by means of weights and pulleys, for very many fractures even of the upper extremity are so treated, and a fearsome picture appears on page 117, in which a patient, with a fractured lower end of his humerus, is being pulled by ropes in no less than four different directions. Splints hardly ever seem to be used; and, though a "Thomas" is recommended, Hodgen's method seems to be unknown. We notice that the author has operated on a fractured neck of the femur, "nailing" it on to the shaft, but he only recommends open operation in the case of the great tuberosity or the external condyle of humerus, in no other fracture does he even discuss wiring. Very good rules are given as to the days on which passive movements can be started, and the weight that can be applied in extension. We particularly like the discussion on the etiology of each fracture; very clear descriptions being given of the nature of the accident that usually causes any particular fracture; in fact, we think that Dr. Kocher would prefer to classify fractures according to their cause, and their cause only. He generally gives an anæsthetic for the purposes of diagnosis, and points out the extreme rarity of a pure intracapsular fracture of the neck of the femur—never having seen one himself.

A most excellent and carefully written work which will well repay perusal.

Errors of Refraction and their Correction. By H. B. Grimsdale, pp. 87. (The Medical Times, Limited). 2s. 6d. net.

This small manual is written with the object of enabling the medical man to order spectacles for his patient, and so will prove useful to those practising in the country: those living in London will probably find it more convenient to recommend a specialist, or a hospital, as the case requires. An excellent, short account is given of the elementary laws of light, with some very clear diagrams, and there is a very good description of Retinoscopy: useful rules are given for the determining of the lens required, and a chapter on the merit of different frames. Among many useful hints we notice one—that no patient, older than thirty, should be allowed to go away after being homatropinised, without counteracting its effect by eserin, owing to the risk of acute glaucoma.

Practical Prescribing and Dispensing. By William Kirkby, pp. 169 and vii. (Sherratt & Hughes.) 4s. 6d. net.

This is another addition to the list of books—already long—which attempt to fill the gap admitted by all to exist in the teaching of most medical schools. The first part of the book consists of explanations of the technique of prescribing—where we notice that the most convenient sized pill is one of three grains—we thought four was more usual. There is a good chapter explaining percentage solutions, etc., and the bulk of the book is made up of a list of the principal drugs, with their incompatibles and usual methods of prescribing. We notice that no mention is made of the fact that Caffeine requires suspending in a mixture, and also that Mr. Kirkby was formerly a lecturer in pharmacognosy.

A Complete Handbook of Midwifery. By J. K. Watson. Pp. 348. The Scientific Press, Ltd. 6s. net.

This is an elementary text-book intended for midwives and as such seems to fulfil its purposes admirably. At the beginning the author is met with the old problem as to how much a midwife should be required to know and how much she should be allowed to do. Very full details—for such a work—are given of everything, as Dr. Watson considers that the more the midwife knows the

better she is able to judge where the limit lies between her duties and those of the medical man. The book opens with an excellent account of the anatomy of the pelvis, short and yet not omitting a single important fact, and we are then given all the usual descriptions of normal labour and explanations given for the diagnosis of abnormal labour. The last half of the book is filled with more advanced midwifery and various operations, a knowledge of which enables the midwife better to assist the operator. A very good book, perhaps a little too full for midwives.

The Signs of Life from their Electrical Aspect. By Augustus D. Waller, pp. 175, and viii. (John Murray) 7s. 6d. net.

This book is published under the authority of the University of London and constitutes the first points of their newly founded physiological laboratory — being a series of lectures delivered there for advanced students through apparently the work was done elsewhere. In an introduction the author lays down a few rules for lecturing, in which he says that a teacher of University rank should be not only learned but also learning—a maxim which we hope this young University will keep in mind and so avoid some of the mistakes of her older sisters. The lectures largely consist of experiments clearly described and with excellent diagrams, the result of Mr. Waller's original investigations for the last twelve years. Many of the experiments are of the type familiar to the student of physiology in the machine room, but they all prove most interesting reading. By various steps the author proves that in every case examined the electrical responses to electrical stimulation are a token and measure of vitality; he examines in turn seeds, an ivy shoot, a microbe and an eyeball. He finds that seeds though kept a long time and failing to give one of the usual tests of life, namely the expiration of CO_2, yet responded electrically when properly stimulated. In this connection it is interesting to note that Mr. Waller could get no electrical response whatever from the Egyptian mummy seeds. An eyeball recently cut from an animal, when stimulated by light, gives a positive electrical response which can not be obtained if the eye be momentarily plunged into boiling water. As an instance of vitality after apparent death, the author mentions that when Napoleon's body was exhumed at St. Helena for removal to Les Invalides, twenty years after burial, it was found that his nails had grown through his boots.

The study of X-ray photographs of normal bones is urged as a necessary preliminary to accurate estimation of the results given in pathological cases—a timely warning.

A good index accompanies a volume which is well worth reading through once, as many points occur which are not emphasized in the ordinary text books.

In excellently written monograph Mr. Waller has gone far towards teaching us how to measure life in its many and varied aspects.

Testimonial to Dr. Eyre.

DEAR SIR,—I am pleased to say a sufficient sum, viz., £129 11s. 6d., has been subscribed to defray Dr. Eyre's costs in the recent arbitration between him and the Scottish Accident Life and Fidelity Insurance Company, Limited.—Yours truly,

J. H. BRYANT.

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From the Gazette's Special Pathologist.

NOTICES.

H., RAMSGATE.—This specimen is characterised by a great growth of fibrous tissue between the gland tubules of the breast, separating them into clumps large and small. It may be described as a fibro-adenoma. There is no evidence of malignant change.

PATHOLOGIST.

The uses of Electricity and Light in Surgery.

TREASURER'S PRIZE ESSAY.

Paper read before the Physical Society, by J. SEPHTON COOPER, M.A., M.B., B.C. (Cantab.)

THE subject of electricity and light which we have under consideration to-night is full of interest from the therapeutic point of view, quite apart from the wonderful discoveries that have of late years been made in electrical and other allied sciences. It is only within the last decade that electricity has been countenanced by the medical profession, and the reason for this is not hard to find. Electricity is an invisible force which cannot, or rather, could not be weighed or measured, and so naturally enough it was completely enveloped in mystery, and if, even to the present day, the public mind tends towards the miraculous, much more was this the case in mediæval times, when there were no such things as steam engines and the vast array of mechanical contrivances which now surround us. Hence it was that certain unscrupulous persons vaunted marvellous cures by means of this weird and strange force—Electricity. We read, for instance, mythic stories of the employment by the ancients of natural reservoirs of electricity, such as the bathing of patients in water containing electric fish, more especially eels; these can, however, only interest us as feats of imagination, or at most, are of historic interest. The ancients knew of the power of amber to attract light bodies when rubbed, as is reported by Thales of Miletus, B.C. 600, and Theophrastus; but this and jet were the only substances known to possess this property till the time of Elizabeth, when Dr. Gilbert, of Colchester, discovered a large number of others with a like property.

Previous to this, in the 14th Century, we find the earliest allusion to light treatment. In Sir Thomas Watson's "Principles and Practice of Physic" (also quoted in Sir Erasmus Wilson's book on diseases of the skin), is the following:—"He (Gaddesden) surrounds the half-suffocated patient with red curtains, red walls, red furniture of all kinds, everything he saw was to be red, for in that colour there was, John pretended, a peculiar virtue. This John of Gaddesden was, by the way, a very sad knave, and the first Englishman, I believe, who had the luck to be made Court physician. He had one medicine so good as to be fit for the rich only, and he recommended a double dose for the wealthy." Referring to the same subject is this further quotation from Gregory's "Lectures on the Eruptive Fevers": "What think you of a prince of the blood royal of England (John, son of Edward II.) being treated for small-pox by being put into a bed surrounded with red hangings, covered with red blankets and a red counterpane, gargling his throat with mulberry wine and sucking the red juice of pomegranates? Yet this was the boasted prescription of John of Gaddesden, who took no small credit to himself for bringing his royal patient safely through the disease."

It is a curious coincidence that it should be the same disease which has quite recently been engaging our attention with the same red light cure, and which has by most English authorities been accepted with as little credulity as Dr. Gregory expressed in the case of John of Gaddesden, though Finsen and several continental observers, especially Swedes, are firmly convinced of its efficacy.

To return to the subject of electricity, we find the first frictional machine was made by Von Guericke, in 1663. After this the clinical reports of De Haven, of Jallebut and Manduyt, appeared and showed some most phenomenal successes which cannot possibly be believed. Then we hear that there was so much exaggeration of its usefulness, and so much quackery and charlatanism, that at the end of the 18th Century it fell into disuse by all self-respecting practitioners.

It was not until Oersted discovered the force of magneto-electricity, and a few years later, in 1832, Faraday discovered electro-magnetic induction currents, that electro-therapy came into use again. Still, only in quite recent times has it been used at all extensively. It is interesting to note that among the earliest writers on the subject the names of three Guy's men are prominent: namely, Addison in 1837, Golding-Bird in 1841, and Gull in 1852, and their contributions may be found in the hospital reports for those years. It is on the original works of Duchenne and Rémak that most of our knowledge of the physiological action of electricity is found, and it is on this action that the therapeutic uses of electricity are based.

In 1896 Röntgen made known his wonderful discovery, and in 1897 Finsen published his work on the "light" treatment of lupus. Then, most recently of all, the marvellous properties of radium have been discovered, which upset theories it has taken centuries of research to form.

I propose first to briefly discuss the relationship of all the various *forces* used, that is electricity, light, both the visible spectrum and the invisible, ultra violet, and the X-rays. Next, I propose to take the different groups, electricity, light, X-rays, and radium in their reference to diagnosis, prognosis and treatment, and then follow with a comparison of the various forms according to the most recent writers.

Such forces as electricity and light, different as they are, bear a distinct relationship to one another, some forms at least possessing properties in common although each may possess some characteristic property or properties not found in others. Some can be polarised, others cannot; some act on photographic plates such as light, radiant matter, and even heat. In therapeutics we find that radiant heat, light natural and artificial, and X-rays, possess certain common properties in different degrees, but they differ in other respects. Great power of penetration is possessed by X-rays and the tendency to flow over large and extensive surfaces as is characteristic of high frequency and high potential currents.

A diagrammatic spectrum can be made based on the familiar one of light; on the very extreme left are the electric waves of very long wave-lengths, perhaps miles long, then the N-rays which are said to emanate from the human body; further to the right are the infra-red or heat rays, then comes the usual light waves in order, red, orange, yellow, green, blue, indigo, violet; and next are the ultra-violet rays, next a group of rays causing fluorescence in certain bodies, the Becquerel rays, the Cathode rays, and on the extreme right the X-rays. The rays of radium come in somewhere about the position of the Becquerel rays but it gives off three varieties of rays called alpha, beta, and gamma. The alpha, forming 99 per cent. are rays of particular parts; the beta are probably the same as the Cathode rays, and the gamma are probably the same as X-rays. This element is too rare for much work to be done, but it certainly has an effect on the skin as Dr. Macintyre and M. Becquerel have proved. It is evident that if the same effects as are now produced from the Crooke's tube—and the present X-ray tube is only a modified form of Crooke's tube—could be produced by the application of a salt such as radium bromide, much complication in apparatus would be avoided.

The first part of this paper will begin with the ordinary electric current familiar to all as the galvanic and Faradic currents. These can be used in the diagnosis, prognosis, and treatment of cases.

As an aid to diagnosis it may be used with advantage in the injuries and diseases of muscle and nerve. The two must be taken together, as it is by the reaction of the muscle that we deduce the condition of the nerve supplying it. For this purpose both the galvanic and Faradic currents must be used, since one without the other might lead to fallacious results. The method of application I shall not discuss. Nor do I intend to say anything about the normal physiological actions of muscle and nerve.

The electrical changes a muscle may undergo as the result of disease or injury may be classified as (*a*) changes in the quantity of response, the quality not being otherwise changed; and (*b*) changes in the quality of response. These are the reactions of degeneration, complete and partial.

(*a*) Small qualitative changes are not easy to make out, and are fortunately unimportant in diagnosis Large changes are readily observed.

(*b*) The quantitative changes are far more important. Briefly, the reaction of degeneration consists in the loss of irritability of nerve to all stimuli, and of the muscle to the Faradic current; the muscle contracts on stimulation with the galvanic current, but the contraction is sluggish and the anodal closing contraction may be greater than the cathodal.

If the nerve ends are united and recovery takes place, then voluntary movements in the muscles again becomes possible, muscular regeneration commences, electrical reaction gradually returns, and the irritability gradually rises to its former condition. But, as Erb remarks, irregularities may occur depending on the peculiar nature of the disease or injury or accompanying circumstances.

From this it will be seen that electrical examination will determine the condition of the muscles and nerves, and form a basis for treatment. It may be used to distinguish whether paralysis is due to a cord lesion or due to nerve injury; for example, the distribution of a paralysis affecting some of the muscles of the hand might enable us to distinguish between a lesion of the median nerve on the one hand and the eighth dorsal and first cervical roots on the other; in the latter the whole of the thenar and hypothenar eminences, and all the lumbricales and interossei would be involved; in the former many of the muscles would escape, namely, the hypothenar, the interossei, the inner two lumbricales, the adductor pollicis, and the inner half of the flexor brevis, all of which are supplied by the ulnar nerve. In the following case the result of electrical examination saved the trouble and risk of a formidable operation. A woman fell and injured her head; she was picked up unconscious and with paralysis of the arm; the opinion of several people differed as to whether the paralysis was due to head injury or not. Well-marked reaction of degeneration was found, and so conclusively proved that paralysis was due to injury of the brachial plexus or lower nerves. Reaction of degeneration does not occur in paralysis due to upper nerve injuries, or in primary muscular disease.

Sometimes the question arises: Is the nerve divided or only injured? Reaction of degeneration will follow both division and injury of a nerve, and it is only by considering all the circumstances of the case that an opinion can be formed. The following case illustrates this well:—A barber was pursuing his occupation on board ship, a sudden roll caused him to stumble and he ran the scissors into his axilla; the bleeding was considerable, so the part was tightly bandaged and remained so till he was put ashore in three or four days time. He was then found to have an extensive paralysis of the muscles of the forearm and a traumatic aneurysm in the axilla. The question arose as to whether there were any nerves divided. He showed reaction of degeneration in the ulnar and musculo-spiral regions, though in the latter the triceps did not show a complete reaction, and the ulnar paralysis was not absolute, neither was wasting extreme nor sensation altogether lost. The report was made that the nerves were probably not divided; there was no operation and under electrical treatment he recovered.

Put in a general way anything incomplete in the symptoms of the paralysis would point to injury rather than division of a nerve. In total division the reaction of degeneration comes on much more rapidly.

Another question likely to arise after the ends of a divided nerve have been united by operation is, "Has proper union taken place?" It is difficult to answer this as the normal reaction seldom returns until too late to be of any prognostic value, we may still find well-marked reaction of degeneration when the sensation and power are returning. If contractability to the Faradic current returns early it is a good sign.

This latter consideration brings us to the use of the current in diagnosis. This may be stated quite shortly in the words of Erb. "Other things (that is the cause and nature of the disease) being the same the lesion is serious, the probable duration of the disease longer, and a definite prospect of cure more remote in proportion as the reaction of degeneration is developed and complete, and in proportion to the stage it has reached."

The prognosis based upon reaction of degeneration in, for example, simple facial palsy, varies with the severity of the affection, in *mild* cases with reaction normal it is likely to last about three weeks. In *intermediate* cases, when the reaction of degeneration is partial, the disease will last from one to two months. In the most severe form when there is complete reaction of degeneration, the disease may last three to nine months or more; but it must be noted that much depends on the cause, as palsy, due to caries of the temporal bone, is likely to be much more serious than that due to cold. Reaction of degeneration does not of itself mean irreparable mischief, and may be relatively of good omen when compared with severe intractible conditions as spasms, tremors, and convulsions, in which there is no reaction of degeneration.

In talipes electricity will help us to find out what healthy muscle there is left and so enable us to form an opinion as to the ultimate use the limb may be to the patient and guide us in our efforts to render it more useful by surgical means. Thus in talipes calcaneus if we find by electrical examination that there is a considerable amount of healthy tissue in the calf muscles, the tendo-Achilles may be shortened and the foot thus restored to a more useful position, and similarly in other deformities it may help to use what material there is to the most advantage. Further than this electricity will not help us and we must rely on other methods, but in the cases mentioned, and in similar cases, it is of much advantage to have even a little help.

There is not very much to say about the therapeutic uses of electricity in surgery, for no one really knows why it does good, and it is used quite empirically. It may be that it is due to general nutritional changes; such have been shown to occur by d'Arsonval in his experiments with the high frequency current; he found an increase in the intake of oxygen and the output of carbon-dioxide as well as a diminution of the body-weight. In all probability the psychic or mental effect has a great deal to do with improvement. The local application of the galvanic current seems to have a stimulating action on the tissues when applied ocally, and there is also in some cases of nerve lesion accompanied by pain, a sedative effect. The Faradic current producing contractions of muscle is also of much use in keeping a muscle "fit," while the injury to its nerve is being repaired, and also in such cases as infantile paralysis, where part of a muscle is healthy its tone may be much improved by electrical treatment.

With these considerations in mind a whole list of instances in which electricity may be useful suggests itself; generally speaking these are injuries to nerve and muscle and atrophy of muscle from disease. Other trophic changes may be treated, as, for instance, Reynaud's disease, and chilblains, whilst osteo-arthritis is said to be benefited with application of the high frequency current, the treatment causing an increase of blood-flow to the part.

Piles also and other conditions of dilated veins have been treated with some success by the same method. Professor Doumer, of Lille, says that he has used this treatment, and cure was the rule. I have since heard from more than one authority that it was very beneficial.

Into the subject of high frequency current as of static electricity I do not intend to go further, as the use is more medical than surgical, and their benefits react more on the whole body than on any one part.

In surgery the chief use of electricity is electrolysis. By passing a galvanic current through the body we decompose its tissues, the products of decomposition appearing at the points where the current enters and leaves the body, acids and oxygen at the anode, alkalies and hydrogen at the cathode.

The advantages of electrolysis are four-fold:—

1. We can get local decomposition to the required extent.
2. It introduces no poisonous caustic.
3. There is scarcely any after pain; and
4. Absorption of its products need not be feared.

The application may be made in one of these ways:—

The bipolar method when both poles are inserted into the tumour; this is quick but is liable to leave scars.

The unipolar method; this is slower, but if the negative pole is the external one the risk of sloughing is at a minimum.

Or lastly, with both poles in close apposition, but not inserted through the skin or mucous membrane; this method is not much used except in Apostoli's method of treating uterine fibroids.

The commonest diseases or conditions which can be treated by these methods may now be considered. In a paper of this sort detailed description of methods would be out of place, considering the amount of ground one has to cover.

In Hypertrichosis very good results may be obtained, but in an extensive case many sittings must be given, as only a few hairs can be removed at a time, and great care must be taken to prevent sloughing. The unipolar method is employed and the negative electrode is the one used to plug into the follicles.

In Cheyne and Burghard's Surgery it is stated that forty hairs may be removed at a time, and Lewis Jones is in agreement with this; Dawson Turner, however, puts it at as few as ten to fifteen. The part remains red and œdematous for two or three days, and then leaves no visible scar. Cheyne and Burghard put the number of failures by this method at 1 per cent., a result which it would be difficult to improve on. By this means it would be a matter of great difficulty to remove fine hairs over an extensive area, and when discussing X-rays I shall endeavour to draw a comparison between the two methods.

Small pendulous tumours may be removed by introducing either pole, but preferably the positive, as though slower, it leaves less scar.

Warts are not successfully treated by electrolysis. nævi, when superficial should, according to most authorities, be excised or cauterised; for deep ones, where there is risk of extensive scarring and injury by removal or cauterisation, electrolysis is far the better. Electrolysis does not give good results with port wine stains, but it may be tried in combination with caustics, for example ethylate of sodium. In the electrolysis of deep nævi there are several important things to think of. Either the unipolar or bipolar methods may be used: in the former there is less chance of scarring if the positive pole is inserted, the latter, however, being much more rapid.

It is important to insulate that part of the needle which passes through the skin, or there may be sloughing. The needles, if several are used, must be kept parallel to distribute the effect, and if the unipolar method is employed, the negative pole outside should be shifted about round the nævus.

The current is passed until the nævus feels firm to the touch, usually in about ten minutes.

The positive needle is apt to stick, and then it is necessary to reverse the current for a few seconds, when it will be loosened; this is due to the fact that around the positive pole there is found a hard firm clot, and around the negative a soft frothy clot. As in all surgical proceedings, it is necessary to sterilise the skin, and a general anæsthetic is desirable, as electrolysis is painful, especially when the current is made and broken, which should be done gradually. The operator should be on the watch for shock, especially when the nævus is on the anterior fontanelle in infants. For a large nævus one sitting is rarely enough, the treatment may be repeated at intervals of eight to ten days, but the effect can only be determined after the hardness has passed off.

Opinion differs in the treatment of cirsoid aneurysm. Cheyne and Burghard say that treatment by electrolysis is "more or less ineffectual." Dawson Turner says "they are very amenable to electrolysis, and can always be cured by it." Dr. Duncan says he has cured every case he has had by electrolysis. Many attempts have been made to deal with aneurysms, with varying success, those which have received most attention being the thoracic ones, which cannot be dealt with otherwise.

It was hoped that the clotting round the poles might be the nucleus for further clotting, and thus the cavity filled up.

Cinicelli treated thirty-eight cases, using both poles, and reversing the current every five minutes; twenty-seven were ameliorated, none cured. Dr. John Duncan treated popliteal, femoral and axillary aneurysm by this method, and cured sixteen out of twenty-nine cases. He only obtained six cures out of thirty-seven cases of aortic aneurysm.

Dr. Petit treated one hundred and fourteen cases of aortic aneurysm, with improvement in sixty-eight.

Dr. Duncan inserts both needles, and from time to time brings the positive needle into contact with the sac wall so as to roughen it, as an aid to further clotting. He has had two very satisfactory results.

The needle should be insulated when it passes through the wall, otherwise sloughing and hæmorrhage might occur. The dangers of this operation are hæmorrhage, suppuration and embolism, but of the latter Turner says he has seen no case reported.

Stuart, of Philadelphia, has had some very good results by combining electrolysis with the introduction of a foreign body, namely, wire.

Goitres, especially the soft and vascular varieties, are said to have been benefited by this treatment. Dr. John Duncan has had some excellent results.

Dr. Kuttner, of Berlin, has treated nine cases by the introduction of the negative needle only, and of these two were completely cured, and five greatly ameliorated.

Electrolysis has been fairly extensively tried in stricture of the urethra, rectum, Eustachian tube, œsophagus and lachrymal duct. The advantages advocated are that it is safe, there being no bruising; it is less painful, there is no hæmorrhage, and for all these reasons less shock. Its disadvantages are its slowness and expense, and it is decidedly dangerous in inexperienced and rash hands.

No surgeon will choose this method when in a much shorter time and by a comparatively simpler method he can dilate the urethra, unless he have the special knowledge or apparatus electrolysis entails, and moreover, there is no great abundance of evidence to show the superiority of electrolysis.

Mr. Bruce Clark quotes fifty cases, twenty-three of which were known to be well from one to one and a half years afterwards. On the contrary, Mr. Henry Fenerich stated that twenty picked cases so treated were all made worse.

Dr. Fort, of Paris, has treated seven hundred cases by linear electrolysis without a single fatality. He considers it the treatment par excellence.

Not enough work on stricture of other organs has been done to render its inclusion here necessary.

The subject of Apostoli's treatment of uterine fibroids has been much discussed, and opinion is much divided on the subject. Apostoli, at the meeting of the British Medical Association in 1887, stated that in 95 per cent. of cases permanent benefit was obtained. Whereas Herman, in his *Diseases of Women*, says there is no evidence of any such action of electrolysis in causing shrinking of tumours, and he mentions Stuart Nairn's analysis of cases; out of one hundred and six so treated, the results were good in twenty-eight, indifferent in thirteen, bad in twenty-one, and very bad in forty-four.

In sixteen years it has not attained much support, so we may consider it has not justified itself, in England at any rate.

The uses of the electro-cautery may be dismissed in a few words as the result is due to the heat, not to the electricity. It forms a very useful and convenient piece of apparatus, but most things that can be done with the electro-cautery

can also be done with the Pacquelin's cautery. One great advantage is that the electro-cautery can be placed in position first and then the current turned on, and also the red hot point is kept constantly hot and is not cooled by the tissues.

Cohen, in his book *Physiologica Therapeutica*, mentions the following cases in which the cautery may be used:—

Hæmorrhage: the cautery being at a dull red heat.
Laryngeal ulceration.
Laryngeal and pharyngeal growths: in granular pharyngitis and also in hypertrophic rhinitis, when the enlargement is due to mucous membrane and not bone.
As a counter irritant.
In chronic ulcers.
To destroy the nerves of teeth.
In operation for hæmorrhoids.
In rectal polypus.
In adenomatous goître.
In opening abscesses, for example, of the lung and liver: it seals up the tissues through which it passes.

It has been used to open tubercular abscess of the lung with success by Sonnenburg.

An instructive use of the electro cautery is in cases of hypertrophy of the prostate. This treatment was introduced by Bottini, of Padua, who burned furrows in the obstructing parts with, on the whole, favourable results. An instrument is used which combines an incisor knife, a cautery of small plates, and tubes for the circulation of water. The instrument is passed with the patient in the lithotomy position, and after bringing the curved brake in contact with the part to be removed, the current is turned on, it is moved gently backwards and forwards till the obstruction is removed.

Bottini's results are as follows: out of 164 cases treated, 80 were cured, 44 improved, 26 not improved, and 14 died, whether from the use of the instrument is not stated. Electrolysis may also be employed in this disease, and is on the whole safer.

D'Casper, of Berlin, employs electrolysis by galvano punctures.

Electricity in the form of light is becoming more and more used every day. Apart from its therapeutic effects, as discovered by Finsen, the use of electric light is mechanical only and is used to illuminate cavities. Many forms of lamp have been devised, among these may be mentioned the various forms of forehead lamps, small lamps for introducing into the abdominal cavity during operations, lamps for throat, nose and ear examinations. Transillumination is of great aid in the diagnosis of some diseases, such as hernia and hydrocele, antral disease, and even tumour in the stomach wall.

One of the most important uses of electric light is the illumination of the bladder. This is done by means of the cystoscope, which instrument enables one to examine visually the whole internal surface of the bladder. By its means also the difficult operation of catheterisation of the uterus can be carried out. This latter operation is unfortunately not much used in England, but in America and on the Continent it is extensively employed to determine the state of the kidneys before operation for tumour or stone and other disease.

Similar lamps are made for the direct examination of the œsophagus and stomach. Mere mention only need be made of the electric light bath. It consists of a cabinet containing forty or fifty incandescent lights, within which the body is confined. Great heat is brought to bear on the patient, and it is said to benefit osteo-arthritis and similar complaints. Some claims, disputed by Finsen, have been made that this is not simple heat but that there are actinic rays given out in considerable amount, but whatever rays there are must be absorbed by the glass of the lamp.

(*To be continued*).

Papers by Guy's Men.

The Wightman Lecture on the Hereditary Bias and Early Environment in their Relation to the Diseases and Defects of Children. By R. Clement Lucas, B.S., M.B. Lond., F.R.C.S., Eng.—*Lancet*, 30th July.

The Red Light Treatment of Small-pox. By T. F. Ricketts, M.D., M.R.C.P. Lond.—*Ibid.*

Note on a Case of Cæsarian Section for Reniform Rachitic Pelvis. By J. B. C. Brockwell, M.R.C.S., L.R.C.P. Lond.—*Ibid.*

On Diaphragmatic Hernia of the Stomach, and on Torsion of the Small Omentum and Volvulus of the Stomach in Association with it. By R. Lawford Knaggs, M.C., M.D. Cantab., F.R.C.S. Eng. Illustrated.—*Ibid*, 6th August.

Nephritis in Infantile Scurvy. By Geo. F. Still, M.A., M.D. Cantab., F.R.C.P.—*Ibid.*, 13th August.

Progeria. A Form of Senilism. By Hastings Gilford, F.R.C.S. Eng. Illustrated.—*Practitioner* for August, 1904.

Choline—a new method of testing for its presence in the blood and cerebro-spinal fluid. By R. W. Allen, M.A., Gull Student in Pathology.—*The Journal of Physiology* for August, 1904.

The influence of changes in the intraocular circulation on the intraocular pressure. By E. E. Henderson, F.R.C.S., and E. H. Starling, M.D., F.R.S.—*Ibid.*

The influence of fasting and feeding upon the respiratory and nitrogenous exchange. By M. S. Pembrey, M.D., and E. Ivens Spriggs, M.D.—*Ibid.*

The Quantity and Pressure of Carbon Dioxide in Venous Blood and in Alveolar Air in cases of Diabetes and Diabetic Coma. By A. P. Beddard, M.D., M. S. Pembrey, M.D., and E. Ivens Spriggs, M.D.—*Ibid.*

A Case of Glioma of the Spinal Cord. By F. Macdonald Gill, M.D. Lond.—*The Australian Medical Gazette* for July, 1904.

A Plea for Oral Hygiene. By K. W. Goadby, D.P.H L.D.S.—*British Medical Journal*, 27th August, 1904.

Change of Address.

Sir Henry G. Howse, from 59, Brook Street, to 22, Grosvenor Street, Grosvenor Square, W.

Dr. R. D. Attwood, from the Sick Asylum, Bromley-by-Bow, E., to St. Saviour's Infirmary, East Dulwich, S.E.

Dr. George Beley, from Wynaad, Southern India, to Wandsworth Infirmary, St. John's Hill, New Wandsworth, S.W.

Dr. Edmund C. Bevers, from 77, Woodstock Road, to 40, Beaumont Street, Oxford.

Dr. J. A. Butler, from Jalpaiguri, Assam, India, to Hillside, Widford, Ware, Herts.

Dr. F. G. Gibson, from the Heath Asylum, Bexley, Kent, to Papanui Road, St. Abans, Christchurch, New Zealand.

Dr. P. C. P. Ingram, from St. Saviour's Infirmary, East Dulwich, to 416, New Cross Road, S.E.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Chapel Fund.

ADDITIONAL CONTRIBUTIONS TO DECORATION ACCOUNT.

	£	s.	d.
Amount previously acknowledged	150	5	0
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Pupils' Physical Society.

SESSION 1904–1905.

The opening meeting of the Session will be held in the SMOKING ROOM of the Students' Club on Saturday, October 8th, at 8.30 p.m. Sir Samuel Wilks, M.D., LL.D., F.R.S., will take the Chair, and the Society will be addressed by Professor Alexander MacAlister, M.A., M.D., LL.D., F.R.S., of Cambridge.

The President of the Society will entertain Sir Samuel Wilks and Professor MacAlister to dinner in the College, at 6.45 p.m. Past or Present Guy's men who wish to be present at this dinner may obtain tickets, price 3/–, from the Secretaries of the Physical Society, Guy's Hospital, or from the Steward, at the Club.

Appointments.

Civil.

ATTWOOD, R. D., M.R.C.S., L.R.C.P. Lond., has been appointed Second Assistant Medical Officer at the St. Saviour's Infirmary.

Military.

Captain H. D. PEILE, I.M.S., has been appointed Superintendent and Medical Officer of the Central Jail, Raipur, Central Provinces, India.

The King has been graciously pleased to confer the Companionship of the Distinguished Service Order on Lieutenant J. H. Horton, Indian Medical Service, in recognition of his services during the operations in Somaliland.

Lieutenant Horton was present throughout all the operations against the Mullah, and latterly was in Medical charge of the Tribal Horse.

Births.

BISSHOPP.—On August 26th, at Parham House, Tunbridge Wells, the wife of Francis R. Bisshopp, M.A., M.D. Cantab., M.R.C.P. Lond., of a daughter.

KIRKBY.—On September 5th, at 87, Earlsfield Road, Wandsworth Common, S.W., the wife of R. C. Kirkby, M.R.C.S., L.R.C.P., of a son.

NOLAN.—On 19th July, at Cairo, the wife of H. Nolan, LL.D., M.D. Lond., F.I.C., of a son.

STURGES-JONES.—On August 25th, at Half Moon Lane, Herne Hill, the wife of W. E. Sturges-Jones, M.R.C.S., L.R.C.P., L.S.A., of a daughter.

Marriage.

HINDS—BAUCHOP.—On August 17th, at St. Michael's, Smarden, Kent, Herbert Austen, M.R.C.S. Eng., L.R.C.P. Lond., of Shalmsford Street, near Canterbury, son of William Hinds, Esq., of Chessenden, Smarden, to Annie M. A., daughter of the late Robert Bauchop, of Port Chalmers, New Zealand.

Death.

COCK.—On August 30th, at 147, Queen's Road, S.E., Herbert Edgecombe, M.R.C.S., L.R.C.P., aged 32, eldest son of Dr. and Mrs. Cock.

R. E.—ED.

GUY'S HOSPITAL GAZETTE.

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CONTENTS.

	PAGE.
To the October Freshman	373–375
Passim	376–378
Some Acute Abdominal Cases. Clinical lecture by Dr. J. H. Bryant	379–385
Appointments	385
Lectures for Sessions 1904—1905	386
The Sciences	387–398
Correspondence	398–399
Reviews	399
In Lighter Vein	400
A Case of Thrombo is of the Pulmonary Artery following Labour	401
Change of Address	401
Guy's Hospital Clubs' Union	402–404
The Uses of Electricity and Light in Surgery	405–412
Papers by Guy's Men	412

To the October Freshman.

"For the jungle is wide and the Cub he is small. Let him think and be still."

IN accordance with a time-honoured custom, it is the pleasant duty of the writer of this column to extend the hand of fellowship to all of you who have this October entered the Hospital as freshmen, and to add to a hearty welcome to Guy's a few well-worn words of judicious advice. Perhaps by the time this Gazette falls into your hands you may feel somewhat surfeited with judicious advice, but we would point out that up to the present the counsellors have been mainly Olympian, whilst here it is a very ordinary mortal who addresses you, and one whose entry into the Hospital is recent enough history for him to remember very distinctly the gins and pitfalls that so soon beset the path of the unwary. Therefore, O Freshman, listen with bowed head and attentive ear to yet another improving of the occasion.

To begin with, you are to be heartily congratulated first and foremost on your choice of medicine as a profession. The choice of a profession is at all times a weighty matter, and one that cannot be decided without great searchings of heart. No doubt you have your own excellent reasons for your choice and have weighed the pro's and con's as far as is possible without actual experience to aid you. But remember that in electing to serve medicine you are bowing the neck to an exacting task-mistress, who will not scruple to ask sacrifices of you in almost every department of life in which your individual peculiarities of taste and temperament may lead you to exercise yourself. Your outlook upon life as a whole, unless you are content to partition out your mind and to carefully preserve your pet theories as a hot-house gardener his rare and exotic plants, will be powerfully affected by the mental attitude that your work will engender in you, and an enforced contemplation of scientific facts will result in at least an adjustment, if not a total abolition, of many preconceived ideas.

A prospect such as this may not seem exactly exhilarating, and, if this were all, our congratulations on your choice of medicine as your life-work might savour of the sardonic. But there yet remain to be reviewed the advantages which your choice will ultimately give you, and to gain

these is probably worth considerably more in mental wear and tear and personal inconvenience than even the keenest intellect, and the most voracious seeker after knowledge in your ranks, will be called upon to suffer.

From the time that you first begin to feel your feet in your new work, throughout the vicissitudes of your life in the wards, past the time when you shall leave this Hospital a fully qualified man (it has been calculated exactly what fraction of your number attain to this goal), and then onwards into the dim and distant future when you will begin to learn the value of the knowledge you acquire as a student, you will find that, in addition to your power to cope with disease, you are the possessor of an ever-growing faculty (call it what you will) that enables you to do good work in the world, to take a keen interest in life of all kinds, and to understand and sympathise with your fellow-men perhaps more thoroughly than most. In fact, you will be in the position of a man to whom a great trust has been given. You can use this trust in many ways, either as the veriest catch-penny and pedler—in which case it were better that you had never entered the profession, a frankly commercial career of a more or less disreputable sort would have suited you better—or it will be your privilege in all humility to regard your work as many thinking men do regard it, as that of the true "high priest of humanity."

But we had forgotten that your patience has its limit, and it has been sorely tried. The rarified atmosphere of the ideal is apt to be oppressive, and we will descend to plain facts.

You will find your work up here exceedingly difficult, especially at first. Even though you were to follow religiously the various and concise directions printed elsewhere for your guidance, the mere routine alone would avail you nothing. You will find medical knowledge of all kinds particularly difficult to absorb, and particularly elusive. It will be necessary to keep your nose to the grindstone, perhaps more than you anticipate, before you begin to feel your feet in the various subjects. Your progress may strike you as disheartingly slow, but on no account let this worry you; you can rest assured that if you stick to your guns it will all come right in the end. That is a platitude, but even platitudes have their use, and the sagest saws are often the most commonplace. Let it be your ever-present consolation that bigger fools than you have succeeded. If the present writer did not constantly find comfort in this last he would not dare to hand it on to you, it sounds too ambiguous, but in times of stress there is nothing like it as a mental tonic.

Make your own working habits, and, when once you find that they answer, do not let any wiseacre induce you to change them. You will early make the acquaintance of the would-be "smart" man who never reads until about a fortnight before the exam. Such a man is either a fool, a liar, or a genius, and he is rarely the last. By his fruits you shall know him. The pessimism of the "chronic" need not alarm you, he speaks from experience, it is true, but he is rarely the simple victim of hard luck alone.

Above all things do not neglect Honor Oak. Regular exercise will not in any way interfere with your work, and many of our best men in the football and cricket fields have excellent records, both in the medical school and in the wards. It is only too easy for a man, coming straight from school or college, where exercise has been always easily got without any arranging on his part, to fall into bad habits up here. You are probably changing your whole style of existence in coming to London and starting life in "digs," and, if anything, you will want more exercise than ever to make up for the vitiated atmosphere you inhale, the excess of tobacco you will feel it your duty to smoke, and the doubtful food that will dog your footsteps as

you wander hopelessly from landlady to landlady.

You will hear much mention of a mystical process known as "signing up." If you are of an imaginative turn of mind you will connect this idea with that of a lynx-eyed janitor who inevitably knows your goings-out and your comings-in, and who has an intimate knowledge of the number of hairs on your head. You will hear terrible stories of careers blasted by the caprice of a mere demonstrator. All these terrors will be connected in your mind with the words "signing up." We have known men—nay! we know them now—whose ideas on this subject very much resemble those of the heathen on devil-worship. The substratum of truth in all this is simply that from the time you commence work up here, a record is kept of your progress and capabilities by the various heads of departments. It is this record that is consulted when there is any competition in the application for the various appointments, and then, other things being equal, the man with the better "signing up" is the man who will take precedence. It is not fair that you should be ignorant of this supervision, but it is not a thing that need worry you in any way if you are an ordinarily sensible man and stick to your work.

Alas! that it should be necessary to warn the more generous souls amongst you against a too great exuberance of spirits. Boisterousness and horseplay were bad behaviour at school; up here they are bad form, which is worse. Nobody admires buffooning, though it may raise a laugh at the time. Above all things, too, avoid being "shoppy"; there is no more objectionable habit for a medico to fall into. If you wish to assert yourself as a true medical student and a devil-of-a-fellow, for heaven's sake get it over quickly, but remember that it is better for you to throw brickbats at a lecturer than to talk shop in a railway carriage or a drawing-room.

We have congratulated you on your choice of a profession, but it still remains to congratulate you on your choice of a hospital. No doubt you had some good reason for coming here. If, however, the choice was purely fortuitous, then fortune never did you a better turn. You have not chosen a faultless hospital; there will doubtless be bones to pick; you may even find that your experience does not altogether warrant the roseate prospect sketched. But what realization ever did come up to one's expectations?

The main thing about us Guy's folk is that we are all a happy family, and there are few institutions of a similar nature that can boast of such a state of things in their midst. The one thing necessary is that you take us as you find us and then all will be well with you. Do not try to improve us, for that cannot be done. Accept the situation that you are a junior and a cub for the time being; it really means very little, and after all it is excellent discipline to be of little account for a season, whatever venerated institution has hitherto sheltered you, and however glorious your past record. Your worth will be ultimately recognised "both here and in this place;" that is certain.

You will find that life up here gets more interesting when you have left your "Second" or your "Inter." behind you, and have got into the wards, for then your horizon will enlarge considerably and you will get more into the swing of actual hospital life. But you will have a good time in the medical school also, and whether in the wards or in the school you will be laying by a store of memories, to which, if old Guy's men are to be believed, you will hark back in after years and devoutly wish that you could have your student days again. With these rambling remarks we leave you with the best of good wishes to work out your own salvation.

Passim.

THE commencement of another Session is now close upon us, and soon the Smoking-room will become a seething mass of humanity in the middle of the day; then chairs will be at a premium, and the reading of *Punch* an absolute impossibility. The arrival of a number of Freshmen—the greater the better—will make some of us count our few scattered grey hairs that still remain. We have grown old at our post, chained to that wheel which moves with relentless force towards the Embankment, and which, alas! so often returns. We have learnt how to wear a stethoscope and how to look wise, thus often concealing the extreme depth of our ignorance: many things the Freshman will do well to avoid, but experience will teach him more than reams of paper can, close written though they be. We have preached our sermon elsewhere, so will only bid him heartily welcome, congratulate him on his choice of a hospital, and—advise him to be early for lunch and always to turn up a chair.

WE are delighted to see that at the Lambeth Coroner's Court, on Monday last, the jury complained that the County Council pathologist had done the post-mortem and now gave evidence, instead of the house-surgeon, who had seen the man when he was brought in dead into St. Thomas's Hospital. Mr. Troutbeck's answer was that "he did not care to rely on the evidence of a young house-surgeon, perhaps only just qualified." And yet, so far as the report goes, it was an ordinary case of cardiac syncope. Surely he had forgotten that a house-surgeon has had more recent experience of pathological post-mortem appearances than most general practitioners, and is, in addition, within reach of most excellent advice, of which he is almost sure to take advantage on any doubtful point. We wonder if Mr. Troutbeck's clients trusted him when first he was released from his articles.

IN another column we print a letter from a correspondent clearly expressing opinions, which we believe to be generally held throughout the Hospital, as to the objections to the new scheme for Take-in. If the old arrangement had to be changed—of which we are not assured—our correspondent's suggestions seem to meet the case much better than those actually adopted; it distributes the work better, and prevents the rush of new cases coming in so rapidly as under the old plan, though formerly we heard very few complaints, and certainly on the Surgical side everybody concerned—both nurses and men—look forward eagerly to the exciting press of work which Take-in involves. Undoubtedly an H.-P. will take more interest in a case that he has himself diagnosed and found suitable for admission, while, if absent when an acute case is admitted into his ward, as must necessarily happen with great frequency, he will lose the initial treatment, which is so often the most interesting. For the future no H.-P. will be able to absent himself for a single night without the knowledge that he is leaving "nobody bad" behind him. With regard to teaching—it is from the "chronics" that the student can learn most—certainly for examination purposes, as those are the cases on which he will be clinically examined at the colleges, and those are the cases he will be required to treat in general practice. Inability to teach on an old case is a confession of weakness on the part of the teacher, as a fresh aspect can always be obtained by a practised hand. It is interesting to see from our correspondent's letter how one of the new H.-P.'s intend to stultify the new regulations and strangle them at their birth; his suggestions are slightly complicated, but that is no objection to a hospital scheme, otherwise the externs' rotation of cards would have ceased to exist long ago.

WE wonder whether a collection of medical books has ever had a more beautiful home than the library which we owe to the generosity of Sir Frederick Wills. With such surroundings we have a right to expect that the books should be well arranged and well catalogued. Unfortunately, this is far from being the case. There seems to be very little systematic grouping together of books dealing with kindred subjects, and the catalogue is unworthy of the name. Some weeks ago we observed with pleasure a nice boy in an Eton suit emptying the shelves.

At last, we thought, improvements are to take place, but we were doomed to disappointment. Admirable, no doubt, as were the nice boy's intentions, he proved unequal to the task. His knowledge of scientific subjects was unfortunately limited, so that the books returned to their shelves in a slightly altered but hardly improved arrangement. The catalogue is a snare and a delusion. The books are not numbered, so the catalogue gives no indication as to where any required book can be found. It is true that our present worthy Librarian can put his hands on any of the more commonly required books at once. But this he does by instinct, and we shudder to think of what would happen if for any reason he was taken from us, as there would be nobody left with any idea of the geography of the library. It would be like Victor and the instruments when Coles is on his holiday, or the commissionaire and the College when the porters are away.

THIS is not the only fault we have to mention. We recently had occasion to refer to two books which are not often read. Their names were in the catalogue, but the Librarian knew them not. He had a vague idea that they existed, and asked for a week in which to find them. A month has passed, and still they have not been discovered. We have not before asked for books which are not of quite recent date; if the first two we happen to require are lost, it is reasonable to suppose that a large proportion of the older books have either disappeared completely, or at any rate cannot be found on account of the chaotic arrangement of the library. If the present Librarian is too much occupied with his other duties to prepare an efficient catalogue and to properly number and arrange the books, it would surely be worth while to engage some competent person to do this. If funds are insufficient, we should suggest that either subscriptions should be raised for the purpose, or that the arrangement and cataloguing should be undertaken by volunteers among the library readers.

THE Physical Society will hold their inaugural meeting on October 8th, in the Smoking-room of the College, at 8 p.m., at which Professor Alexander Macalister will deliver an address on "Some Pioneer Medical Books," a subject which in his hands should prove most interesting. The Society is to be congratulated on having prevailed on Sir Samuel Wilks to take the chair on that evening; it will be his first appearance at the Hospital since a very serious illness, for his recovery from which we were all so thankful, and we shall accordingly welcome, him if possible, with even greater heartiness than usual. It is hoped that there will be an enormous muster of past and present Guy's men, both at the meeting and at the preceding dinner, 6.45 p.m., for which latter tickets, price 3s., can be obtained from the Secretaries and Presidents, or from the steward at the College.

IN connection with the above we have recently come across an interesting medical report on a case of Dr. Barlow's, written by Sir Samuel Wilks when a ward clerk, in 1845. It is in a neat and delicate handwriting, and relates to a case of phthisis supervening on diabetes; while, as a report, it would serve as a model for all future ward clerks. Several interesting points in the history of medicine are illustrated therein. In the first place, the only observation of temperature occurs on admission, when it is recorded as "moderate,"—it will be remembered that clinical thermometers were introduced to the medical profession by Traube in 1850, but did not come into general use till about ten years later. Again, no mention is made in the report of sugar being present in the urine, though the excessive quantity is recorded, and also its specific gravity, "1040; according to the formula given he would thus pass 20 ounces of solids daily." Willis, in 1674, first mentioned in England that the urine in most cases of great polyuria was sweet, though that fact seems to have been known to the Hindus in A.D. 500, but Dobson, of Liverpool, in 1779, was first to demonstrate the presence of sugar in diabetic urine. No mention of diet occurs, and the principal treatment seems to have been hyoscyamine and morphine hydrochloride.

ON February 28th, 1802, the Guy's Hospital Physical Society presented a memorial in Latin to Edward Jenner, M.D., F.R.S., expressing

their admiration for him, as the discoverer of Vaccine Inoculation. A rough draft exists, signed by all the staff of the Hospital, and by many others. The memorialists are very optimistic, and state their "perfect conviction that this inoculation is a certain preventive of Small Pox, and trust that the Period is not remote when that dreadful scourge of the human race will become totally extinct." Enthusiastic utterances such as these do not often occur in this cautious age, while the epidemic now occurring at Dewsbury shows that "the Period" is still remote, a state of things largely due to the ignorant obstinacy of a small number of the population.

THE authorities of the University of London have at last recognised that the chemistry on which scientific medicine is necessarily based cannot be assimilated in a single year by any but exceptional men. Last year's regulations under which the unfortunate junior students were expected to take the organic chemistry of the Intermediate M.B. at the same time as the inorganic chemistry, physics, botany and zoology of the Pre. Sci., are now happily but a memory, and the course will in future be very much as it was before this disastrous experiment.

THE new Preliminary Scientific men will take inorganic chemistry, physics and biology next July, and should have no difficulty in passing then in all three subjects. The organic chemistry will be studied side by side with the other Intermediate subjects, as hertofore, but the examination (which is henceforth to be known as Pre. Sci., Part II.) will be taken after a year, instead of two years, as formerly. Men who failed or did not go up in chemistry last July can take inorganic chemistry alone next January; they may also take their organic chemistry then, at a special examination, but will be much wiser if they wait until the following July, and avoid the demoralisation of cramming.

IT is to be regretted that the University authorities did not accept the advice of the experts when it was proffered three years ago, but better late than never. The new regulations should work excellently, and materially increase the accessibility of the London degree. London men will in future have finished with pure chemistry a year before they go up for anatomy, physiology and materia medica, and will moreover be credited with a pass in any two of the latter, as a plough in a single subject will be impossible except in very flagrant cases. No man of ordinary ability and industry need in future hesitate to enter for the University course.

AN old Guy's man, who formerly did much work on the GAZETTE, is editing the third largest weekly medical journal—the *General Practitioner* Dr. Percy Allan has only recently been appointed co-editor of this journal with Mr. George Brown, one of the direct representatives on the General Medical Council. For some time previously Dr. Allan acted as assistant editor, and by his exertions has raised the *General Practitioner* to a position of influence and importance. Dr. Allan is, we understand, agitating in conjunction with Dr. Pembrose, M.P., to reform the present system of police fees, and to increase the fee paid for medical services. The Council of the Incorporated Medical Practitioners' Association is protesting vigorously against the action of the Midwives' Board in permitting the appointment of non-medical women to act as examiners, and a deputation from this society is expected shortly to wait upon the Home Secretary and to bring the matter before his notice. We draw the attention of our readers to the debt collecting department of the I.M.P.A.

TILL this year the Guy's Hockey Club has not met with such support as was its due, for absence of ground caused irregularity in the arrangement of matches. This has now been remedied, a "first-class" ground having been obtained at Kidbrooke, three minutes' from the S.E.R. station, and a fixture list, which includes several first class clubs, is being arranged for two teams. It is greatly to the club's credit that, in spite of drawbacks, they won the cup last year, so that now it is hoped that the Clubs' Union will see its way to affiliate the Hockey Club. Many Guy's men are now playing for outside clubs, and hitherto there has been some justification for so doing, but now *esprit-de-corps*, and the firmer establishment of the club, should induce them to play for Guy's only. It is hoped that a large membership and much keenness will be the result of the efforts of the promoters of the club and we wish it every success under Mr. Steward's presidency.

Some Acute Abdominal Cases.

CLINICAL LECTURE By Dr. J. H. BRYANT.
May 11th, 1904.

Gentlemen,—During the last five weeks, since I have been in charge of Clinical, I have had several very interesting cases of acute abdominal disease. These cases have been interesting from the points of view of diagnosis, of treatment, and the effects of treatment.

The first case I propose to discuss with you is that of a boy aged one year, who was admitted on April 1st on account of persistent vomiting and constipation. His mother stated he had never been ill before the night of March 31st, when he was suddenly seized with vomiting and pain in the abdomen. The vomiting continued throughout the night and lasted the whole of the next day. There was no history of any blood-stained discharge, in fact, the mother was emphatic in her statement that there had been complete constipation for two days. I saw the child soon after admission and found him looking very ill; his eyes were sunken, his cheeks were hollow, and the skin over his forehead was wrinkled. The abdomen was slightly distended, and on palpation there was no obvious tenderness, but in the left iliac region there was a feeling of increased resistance which was hardly definite enough to describe as a tumour. There was no evidence of ascites. The rectum had been examined in the surgery but nothing abnormal had been detected. On examining the rectum again in the ward, however, I could just feel a lump with the tip of my finger, but I could not determine whether it was inside the gut or outside and pressing on it. The doctor who sent the child to the hospital had made a diagnosis of intussusception.

Taking into consideration the sudden onset of the symptoms in an apparently healthy child, the persistent vomiting and the absolute constipation, it appeared to be obvious to us that the patient was suffering from acute intestinal obstruction.

The next point to decide was the nature of the obstruction. The age of the child, the indefinite mass in the left iliac region, the tumour felt per rectum, and the previous clean bill of health, pointed to intussusception as the most likely diagnosis.

The child was so ill that we did not discuss the question of endeavouring to reduce the supposed intussusception by means of inflation but came to the conclusion that an operation gave the only possible hope of saving his life. We called in Mr. Lane, and he at once agreed to operate. He opened the abdominal cavity in the median line, and on exposing the peritoneum found a number of tubercles. In the left iliac fossa he found considerable thickening and matting together of a part of the small intestine and the sigmoid flexure, the result of old tuberculous disease. He attempted to relieve the obstruction by freeing the gut, but finding it impossible to do this without rupturing it in many places, and on account of the critical condition of the patient at this stage of the operation, he decided to close the wound and send him back to bed. Death ensued in two or three hours.

At the necropsy, general tuberculous peritonitis was found: the peritoneum was studded with tubercles and the liver was firmly fixed to the under surface of the diaphragm. In the left iliac fossa the lower part of the ileum was matted to the lower part of the colon, and the adhesions were so firm and thick that it was quite impossible to unravel and free the gut, so that it was no matter for wonder that Mr. Lane could do nothing at the time of the operation.

Of course, after the operation and the post-mortem examination it was only natural that we should reflect on our diagnosis of intussusception. It is very easy, however, to be wise after the post-mortem examination. As I have already stated, intussusception is by far the commonest cause of intestinal obstruction in a child. We were misled by the history of the patient having been quite well before the onset of the symptoms for which he was admitted. Although this acute onset was much in favour of intussusception it did not exclude the possibility of tuberculous peritonitis, because the latter disease is sometimes latent and there may be no definite symptoms until some serious complication arises. Then there was the question of the tumour felt per rectum, and the mass in the left iliac region. If we could have determined that the tumour felt per rectum was outside and not inside the gut we should have known that we were not dealing with an intussusception. Then, again, had we felt more than one lump in the abdomen, and had we discovered the presence of free fluid in the peritoneal cavity, we should have been able to diagnose tuberculous peritonitis. Nature has provided me with a short index finger. Had I possessed the index finger of one of our late distinguished surgeons I should have determined that the tumour was pressing on the upper part of the rectum, and

that the obstruction was not due to an invagination of the gut.

When I was in charge of Clinical last year a child was sent to us suffering from acute abdominal pain, vomiting and constipation, the disease having been diagnosed as intussusception. On admission the patient was found to have a distended and tender abdomen. The temperature was high and the pulse was rapid. No tumour could be felt per rectum nor was any blood or mucus found on the examining finger. We did not confirm the diagnosis of intussusception but came to the conclusion that the child was suffering from some form of acute peritonitis, either tuberculous or pneumococcal, or that it was secondary to appendicitis. The sudden onset without any localising symptoms pointed more to a pneumococcus infection. I asked my surgical colleague to see the patient with me and we both agreed there were not sufficient indications for an abdominal section. At the end of a fortnight the temperature had dropped to normal. She soon appeared to get better and about ten days afterwards went out apparently quite well. Two months afterwards she came to my Out-patients and was then found to have a distended abdomen, with redness and œdema of the skin in the neighbourhood of the umbilicus. She had wasted and at this time presented a typical tuberculous aspect. She was admitted and the diagnosis of tuberculous peritonitis was confirmed. I mention this case as the first diagnosis was intussusception.

A third case which I saw in the general medical wards on May 5th is of interest as being a fairly typical case of intussusception. It was that of a boy, aged eleven months, who was admitted for vomiting and passing blood and mucus per rectum.

He had been fed entirely from the breast, and apparently had been perfectly well until the morning of May 5th, when he began to vomit the milk he had taken, and then, what his mother described, as yellow-looking matter. The vomiting continued the whole of the day. At 5 a.m. on the morning of the day he was taken ill he passed a normal motion, but about 5 p.m. he was noticed to strain for a minute or two and then to pass a quantity of blood. This so alarmed the mother that she brought him to the hospital and he was at once admitted. On admission he was seen to be a well nourished child. The pulse rate was 156, the temperature 101·2°, and the respiration rate 42. When I saw the child on the following morning he was lying on his back and crying lustily; his legs were flexed on his abdomen, and he was evidently suffering from severe pain. The abdomen was slightly distended and I could feel on the right side just below the ribs an indefinite sort of tumour. I examined his rectum but found nothing abnormal, but on withdrawing my finger found it covered with dark-looking blood.

The acute onset with vomiting, severe abdominal pain, the discharge of blood from the bowel, and the presence of an abdominal tumour in a child of this age pointed without much doubt to intussusception.

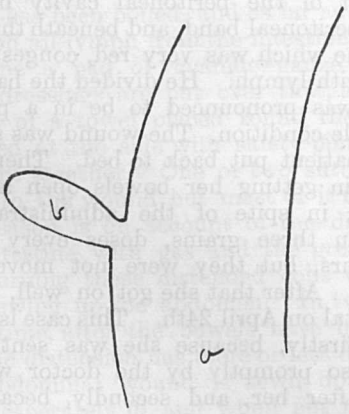
I directed the house-physician to endeavour to reduce it by means of an injection of warm milk and water. The child was anæsthetised for this purpose, and the lump was felt to go back into the right iliac fossa, but as there still remained an increased sense of resistance in this region I asked Mr. Dunn to see the case with a view to laparotomy. He at once agreed to operate, and on opening the peritoneal cavity found, as we suspected, that the intussusception had not been completely reduced. It proved to be one of the rarest forms of the disease, the ileo-colic variety. By far the commonest kind of intussusception is the *ileo-cæcal*, in which the ileo-cæcal valve forms the apex of the invaginated portion of the gut. As the intussusception increases in size the appendix vermiformis gradually disappears from sight. In the *ileo-colic* variety a portion of the ileum is invaginated through the cæcum into the colon, and you can well understand that in consequence the appendix vermiformis is not involved. We knew we were dealing with an ileo-colic intussusception when Mr. Dunn so readily found the whole of the appendix vermiformis.

There are two other varieties of this form of intestinal obstruction, namely the *ileic or enteric*, in which a portion of the ileum is invaginated into the ileum a little lower down, and the *colic*, in which colon is invaginated into colon.

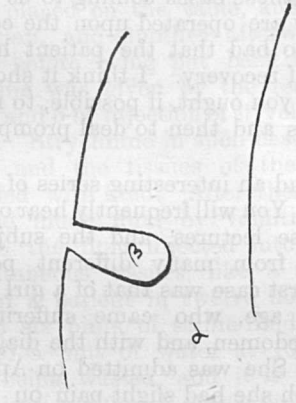
Intussusception is usually produced by undue and irregular peristalsis of the muscle of the intestine set up by the presence of some foreign or abnormal body in the intestine. It may be due to indigestible food, to the presence of some foreign body, or to a polypus of the mucous membrane.

Last year I made a post-mortem examination on a case of ileic intussusception which was caused by the inversion of a small Meckel's diverticulum, so that it projected into the lumen of the gut like a polypus. (*Vide* diagrams).

This inverted Meckel's diverticulum acted as a local irritant, for, being attached to the wall of the intestine, the contraction of the muscle



a Ileum.
b Meckel's diverticulum.



a Ileum.
b Meckel's diverticulum inverted.

above it, in endeavouring to force it along the gut, produced the invagination.

The colic form is most frequently caused by a growth in the colon and is usually chronic.

I will now recapitulate some of the chief points in the diagnosis of intussusception. As a rule its recognition is not difficult. The onset is acute, there is severe abdominal pain of a colicky character, tenesmus, and in many instances an abdominal tumour, and the passage of blood and mucus per rectum. You must not, however, always expect to get such a complete clinical picture. A tumour is felt in about 70 per cent. of the cases and blood in the motions or on the examining finger is found in about 60 per cent. The absence of blood in the first case I mentioned to you to-day did not, therefore, preclude the possibility of the child suffering from intussusception.

With regard to the treatment. If you have a case of intussusception and diagnose it within a few hours of its onset, you will have a very fair chance of reducing it by inflating the lower bowel with either air or fluid. The best form of fluid to use is milk diluted with warm water and in a child a year old you can inject a pint or more. You must anæsthetise your patient and place your hand on the abdomen in order to carefully watch the effect of the injection. In many cases you can feel the tumour gradually disappear, but you can never be certain that the last part of the invagination has been reduced. This method of treatment is more than speculative. If the tumour has travelled round as far as the left iliac fossa, or if the apex of the intussusception can be felt per rectum, there is very little chance of curing the patient by injecting either air or fluid. Having seen many cases treated in a variety of ways I have come to the conclusion that the method of procedure adopted by Mr. Steward is by far the most satisfactory.

The patient is anæsthetised, milk and water is then injected into the rectum and as much as possible of the intussusception is reduced; next, the peritoneal cavity is opened by a vertical incision over the right iliac region, and the last part of the intussusception is exposed and reduced by careful manipulation. The abdominal wound is sutured as quickly as possible and the child put back to bed.

The after-treatment is of the highest importance. Some of you, I have no doubt, imagine that an infant should be kept without food or drink for several hours after an anæsthetic in the same manner as it is customary to treat an adult. An adult is kept without food on account of the liability to sickness; infants rarely vomit after the administration of an anæsthetic. As soon as the child comes round from the anæsthetic it should be given the breast, or if artificially fed should be given milk diluted with two parts of water or barley water. It is quite imperative to supply these little patients with liquid as soon as possible, for the vomiting has probably depleted their tissues of fluids. I have no doubt many children have lost their lives through this point not having been attended to.

The child operated on by Mr. Dunn was given some milk diluted with two parts of barley water as soon as he came round; he took two or three ounces without vomiting and then slept for several hours. When he awoke he was again fed and from this time made an uninterrupted recovery.

The next case of interest which we had was that of a woman, æt. 37, who was admitted for persistent vomiting and constipation. She was sent up by Dr. Partridge as a case of *acute intestinal obstruction.* Seven years ago she had suffered from pelvic peritonitis following a confinement. She was treated for this in the Soho Hospital for five weeks, and apparently got well and was discharged. In November, 1903, she noticed her abdomen was becoming enlarged, and that it caused her discomfort. At the beginning of December she again went into the Soho Hospital, and abdominal section was performed. It was found that the enlargement was due to hydronephrosis on the right side. The right kidney was removed. She was discharged apparently well. On the 31st March, between 9.30 and 10 o'clock p.m., she was seized with severe abdominal pain; she vomited the whole night, and passed neither fæces nor flatus. I believe the bowels had been opened on the morning of the day she was taken ill. Her doctor promptly sent her to the hospital, and when we saw her the temperature was 98·2°, pulse 52, respirations 24. The tongue was coated with a brownish fur, and while in the surgery she vomited almost continuously, bringing up some brownish fluid. The abdomen was not distended and the wall was flaccid; there was the scar of the incision of her previous operation, which was about eight or nine inches in length. Nothing abnormal could be felt in the abdomen, and a rectal examination was negative.

The acute pain and the vomiting, which was persistent, the fact that she had passed no flatus, and that the enema which was given when she came into the ward had no result, led us to conclude that she was suffering from acute intestinal obstruction. The next point was to consider the nature of this obstruction. There were two points in her previous history which suggested a cause. Seven years previously she had had pelvic peritonitis, and about eighteen months ago had been operated on for hydronephrosis. We, therefore, assumed the possibility of peritoneal adhesions, and concluded she was probably suffering from acute intestinal obstruction due to a band strangulating a loop of intestine. Mr. Lane saw the patient, agreed with the diagnosis, and decided to operate. The operation was completed five hours after her admission, *i.e.*, less than twenty-four hours after the onset. Mr. Lane made an incision in the line of the old scar. He first explored the right lumbar region and found a cyst where the right kidney should have been, containing a breakfast-cup full of clear fluid. On examining the lower part of the peritoneal cavity he came across a peritoneal band, and beneath this a loop of intestine which was very red, congested, and covered with lymph. He divided the band, and the gut was pronounced to be in a perfectly recoverable condition. The wound was sewn up and the patient put back to bed. There was a difficulty in getting her bowels open after the operation, in spite of the administration of calomel in three grains, doses every two or three hours, but they were not moved until April 4th. After that she got on well, and left the hospital on April 24th. This case is of great interest, firstly, because she was sent to the hospital so promptly by the doctor who was looking after her, and secondly, because the obstruction was relieved in less than twenty-four hours from its onset when her general condition was so good. Very often we are handicapped in hospital by these cases coming to us so late, for, when they are operated upon the condition of the gut is so bad that the patient has very little chance of recovery. I think it shows that in these cases you ought, if possible, to make an early diagnosis and then to deal promptly with them.

We have had an interesting series of cases of *appendicitis*. You will frequently hear of appendicitis in these lectures, and the subject will be discussed from many different points of view. The first case was that of a girl twenty-one years of age, who came suffering from pain in the abdomen, and with the diagnosis of appendicitis. She was admitted on April 2nd. On March 30th she had slight pain on the side of the abdomen. Next day the pain was worse, and as it was still worse on the following day, a doctor was sent for and appendicitis diagnosed. On April 2nd, as she was still worse, she was brought here and admitted. Her pulse was 118 in the surgery, 122 in the ward. She gave one the idea that she was in extreme pain; her face was pinched, and she was very pale. Evidently she had lost a good deal of fluid from her tissues. The abdomen was not very distended, but it was rigid, and did not move on respiration. The whole of the abdomen was tender, but particularly so over the right iliac fossa. We thought she was suffering from general suppurative peritonitis, the result of gangrenous appendicitis. We all agreed that immediate operation was necessary, so Mr. Lane was sent for, and as soon as possible the abdomen was opened. General peritonitis was found.

Now a word about the way in which these general peritonitis cases are dealt with. Mr. Lane makes a large incision and flushes out the

whole of the abdominal cavity with water which has been boiled, and as far as possible he peels off all lymph from the intestines. Over the intestine a pad of cyanide gauze is placed, other dressings are put over that, and then by means of a towel placed round the body and fastened at the side with safety pins, the parts are kept together. One or two sutures may be put into the wound but most of it is left open. The reason is on account of the distension of the intestine with gas and the great difficulty in returning these distended coils of intestine and sewing up the abdomen. In two or three days time, after the bowels have been opened and the distension has more or less disappeared, the abdominal wound is sewn up. This girl was desperately ill, and when put back to bed was almost pulseless. It was necessary to pay great attention to the after-treatment. She was given an injection of 5 m of strychnine before being placed on the table, another during the operation, and another afterwards, altogether 25 m before being put back to bed. A pint of saline was given by the rectum every four hours and 5 m injection of strychnine every three hours. Strychnine in such cases must be given freely and the tissues of the body must be supplied with fluid. After these patients have lost so much fluid by vomiting, the tissues absorb the fluid injected into the rectum, or subcutaneous tissues, like a sponge. I have known a patient in twelve hours absorb from five to six pints of saline fluid (one drachm of salt to a pint of water at 100°F.) without a drop being wasted, and it is remarkable how the injection alters the appearance of the patient. From sunken eyes and pinched cheeks there is a change to fuller cheeks and an appearance of increasing healthfulness. This case went on fairly well. We had a difficulty in getting the bowels open (though we gave calomel freely), but they were not moved until we gave a glycerine enema. This patient had only one small injection of morphine. In cases which have been operated upon for general peritonitis it is most important that morphine should be avoided. The intestines, as a result of the peritonitis, are already paralysed, and the morphine increases the paralysis. The object after the operation should be to bring about a free action of the bowels; you have got rid of the toxic substances outside the gut, and now you want to clear them out of the inside. I think the best way of doing this is by giving small doses of calomel. It has been suggested that sulphate of magnesia should be injected into the intestine during the operation. But you will remember saline purgatives act by withdrawing fluid from the intestine, and the patient has already lost a large quantity of liquid, so that the hope of a successful examination of the bowels by this means is not often realised.

For a time this girl went on well, that is, until April 15th, a fortnight after the operation. She then began to have signs of a further collection of fluid, and it became necessary to call in Sir Alfred Fripp (in the absence of Mr. Lane) who opened the abdomen and found a collection of pus. A large drainage tube was put in, but a few days after that she developed a fæcal fistula. This fæcal fistula was dealt with some time after, being sewn up by Sir Alfred Fripp. She went on apparently well for three or four days, but it again broke down, and I think it has now been decided to perform enterectomy. When a peritoneum has been operated upon several times in this way there is very little risk of damaging it much further in the way of peritonitis. Enterectomy seems to be the best thing for her. If you had seen her at the time of the first operation and when she was returned to bed you would regard it as little short of a miracle that she is still alive.

Several years ago these cases rarely got well; as a student I do not remember seeing a single case recover. I am convinced there is a very good reason to account for it. I have alluded to the importance of abstinence from morphine. These patients were dosed with morphine before they came to the hospital, and as a result the symptoms were obscured, and when the operation was performed it was too late. It was also a routine measure to give these patients injections of morphine before operation, and then to give it every four or six hours afterwards. The result was that the intestines were kept quiet, the bowels were not relieved, and the patient died from septic absorption.

I have mentioned Mr. Lane's method of dealing with these cases, *i.e.*, a large opening and thoroughly washing out the abdominal cavity. There is a difference of opinion about this, and some of you who read the *Clinical Journal* may have noticed a lecture by Mr. Bernard on the subject. He is opposed to this method of treatment, and says that in cases of general suppurative peritonitis the general peritoneal cavity should not be washed out, for the effect of such a procedure is to wash away the lymph on the surface of the intestine and to open the stomata, in this way favouring the absorption of toxines. I have seen cases dealt with in both ways, and it seems to me a more rational method to get rid of as much of the poison as possible by free incision

and washing out the general peritoneal cavity. The results have certainly been better in the cases which have come under my notice.

The next case was that of a woman, æt. 44, who was suffering from abdominal pain and constipation, and was sent up to the hospital suffering from chronic intestinal obstruction. This woman had been complaining of intermittent pain and constipation for some time. She had had fourteen children, six of whom were living; the last confinement was in July, 1903. A year ago she complained of intermittent pain and constipation, and generally had to take medicines in order to open her bowels. During the last month the pain has been much worse and more continuous, and sometimes she has been constipated for three or four days. She has had no vomiting, but has got a good deal thinner. The day before admission an enema was given, as she had been constipated three days, but only a few hard scybala were evacuated. On admission she was found to have an abdomen very much distended, especially in the lower part, and the distended coils were visible in outline through the thin abdominal wall. On palpation there was tenderness in the lower part of the abdomen, mostly in the right iliac fossa, and it was also tender in the hypogastric region and the left iliac fossa. Rectal examination revealed a swelling which was bulging into the right side of the rectum and was spreading across the middle line. The left side appeared to be free. The age of the patient, the history of the constipation, and the absence of anything suggesting an acute onset, made us think she was suffering from chronic obstruction, probably the result of a growth. The tenderness on the right side pointed to the possibility of it being an obscure form of appendicitis. Later in the day the temperature was found to have risen to 100·2°, and the possibility of some suppuration in the pelvis was also considered. Mr. Lane agreed that it was necessary to operate, and the abdomen was opened in the median line between the pubes and the umbilicus. Many coils of distended intestine were first seen. On manipulating these he came across what appeared to be a cyst, coming up from the pelvis on the left side. On touching this it gave way, and a lot of pus immediately flowed from it. It seemed that in separating the coils of intestine some lymph had been pulled off, and that this thin layer of lymph had formed the wall of the abscess cavity, but had not ruptured before on account of the adherent coils of intestine. On further exploring the pelvis another abscess was found, behind the uterus, and a very inflamed and enlarged Fallopian tube, which had curled round the posterior surface of the uterus, and looked very much as if it was the cause of the abscess.

On further examination, a third collection of pus was found, which was connected with the appendix vermiformis, which organ was inflamed. Both Fallopian tubes and the appendix were removed. On cutting up the Fallopian tubes outside the body no pus was found inside them. The question arose as to the original cause of the pelvic suppuration. Some thought it was primary salpingitis, others that the appendix was the cause of the trouble. Against it being salpingitis was the fact there had been no vaginal discharge and also that there was no pus inside the tubes. I certainly thought the most likely explanation was appendicitis, that she had a small collection of pus in the region of the appendix, and that inflammation had spread and given rise to a further collection behind the uterus and had also caused the swelling and inflammation of the Fallopian tube. The constipation I consider was mechanical and was caused by the pressure of these abscesses on the lower part of the gut. Drains were put into the pelvis, and the patient has done very well indeed, but of course there has been a good deal of trouble on account of a free discharge of pus, but she is gradually getting better.

This case is of interest, as appendicitis was mistaken for chronic intestinal obstruction from growth in the sigmoid. The possibility of appendicitis was, however, duly considered and I was not surprised to find it at the operation, but I must confess that on the whole I was inclined to the diagnosis of chronic intestinal obstruction from growth in the sigmoid. Some of you may suggest that the raised temperature should have made us diagnose appendicitis, but I take this opportunity of telling you it is not at all unusual to get a temperature of 100°, 101° or even 102° in cases of malignant disease of any of the abdominal viscera.

We have had another case of appendicitis, a little girl æt. 6, which illustrates some of the points to be considered with regard to prognosis. She was admitted for pain in the abdomen, fever, and a history of vomiting for three days. The illness began with sudden abdominal pain. There was no history of any previous illness except chronic constipation.

On admission, she was obviously extremely ill, with a temperature of 103°, a pulse of 176, very weak, and respirations 40. The abdomen was markedly distended, moved very little on respiration, was tense, but not very rigid. There

was tenderness all over, but it was not very marked. Her legs were slightly drawn up. Nothing could be felt per rectum. It was evident that the child was suffering from general suppurative peritonitis, and the history of constipation pointed to the appendix as the cause of the trouble. Sir Alfred Fripp saw her as soon as possible, and operated, but he had little hope of her recovery. He made a median incision in the abdominal wall, and when the peritoneum was opened, a good deal of foul pus escaped. She died soon after being put back to bed.

The pulse is a very important guide in these cases of appendicitis, especially when you are discussing the question of operation. If you have an adult suffering from appendicitis with the pulse over 110, or if it persists at from 110 to 120, the sooner that patient is operated on the better. It is not, however, an infallible guide to operation, and the following case illustrates the difficulty we sometimes have in diagnosing and treating cases of appendicitis.

A child seven years of age was admitted with severe pain in the right iliac region on the 20th April. She had been perfectly well until Monday, April 18th, when she complained of severe pain in the abdomen and was sick several times. On the 19th the pain was still severe, and she was again sick. A dose of liquorice powder was given, and the bowels acted twice. As she was still ill on the 20th she was brought to the hospital and admitted. She appeared to be in great pain and distress, and when I saw her she was lying in bed on her back with the right leg flexed on the abdomen. No tumour could be felt, but she had pain and tenderness in the right iliac fossa. A leucocytosis of 23,750 was found. The temperature was 103°, pulse 128, respirations 44. The chest was carefully examined, but no signs of any form of pulmonary disease were found. We thought she should be operated upon. Mr. Dunn agreed with the diagnosis of appendicitis. He was not very keen on operating. However, he did operate, and found she had a perfectly healthy appendix. Three days afterwards definite signs of lobar pneumonia appeared. It is very important to remember this possibility in dealing with acute abdominal disease, because some cases of pneumonia and pleurisy start with acute pain in the abdomen, and these cases are sometimes mistaken for perforating gastric ulcer. I do not think I have ever before seen one mistaken for appendicitis. The pain is generally in the upper segment of the abdomen, but in this case the pain and tenderness were over the right iliac fossa. The respiration was rapid—44—and perhaps that ought to have made us consider the possibility of its being pneumonia, or some disease of the pleura. But physical examination revealed no sign of disease in the thorax. Mr. Dunn's point was that although she had a rapid pulse she did not look so ill as a case of appendicitis usually does. She looked well in comparison with the girl I have referred to, who had a pulse of 176. The lesson really comes to this; that in all cases of acute abdominal disease, especially if the respiration rate be rapid, you should carefully examine the thorax. At the same time you must not be biased in the direction of the thoracic organs simply on account of an increase in the respiration rate, and miss a case of perforating gastric ulcer or perforating appendix, for the delay of a few hours may cost the patient his life.

I have several more cases of equal interest but time will not permit me to discuss them. I will mention one of them, however; it is a boy who is suffering from Henoch's purpura. When he was first admitted, some fourteen days before I took charge of Clinical, his symptoms pointed to appendicitis, and I might add, his appendix vermiformis has had two very narrow escapes from the surgeon.

Appointments.

Civil.

GRAHAM, S. G., M.R.C.S., L.R.C.P. Lond., has been appointed Medical Officer of Health for the Watchet Urban District.

GRIFFITH, O. W., L.R.C.P. and S. Edin., has been appointed District Medical Officer of the Pwllheli Union.

LEVICK, G. K., M.B. Lond., has been appointed Medical Officer of Health to the Havant Urban District Council.

Naval and Military.

Surgeon HERBERT R. H. DENNY, R.N., has been appointed to the *Thames* for the *Forth*.

Colonel F. W. TREVOR, R.A.M.C., has been appointed Principal Medical Officer, Bombay.

Lieutenant F. M. M. OMMANNEY, R.A.M.C., is seconded for service under the Foreign Office.

Captain S. H. BURNETT, I.M.S., is promoted to be Major.

Lectures* for Sessions 1904—1905.

WINTER SESSION. OCTOBER—MARCH.

†	Lecturers.		Days.					
Anatomy (1st & 2nd)	Mr. Dunn and Sir Alfred Fripp ...	9	—	Tu	W	Th	—	—
Microscopical Pathology (3rd) ...	Mr. G. B. Smith and Dr. Eyre ...	9	—	Tu	—	—	Fri	—
Pathological Classes (3rd & 4th)	Dr. Fawcett and Mr. Steward	9.15	—	—	W	Th	—	Sat
Bacteriology (Oct. & Nov.) (4th)	Dr. Eyre	4	—	Tu	—	Th	—	—
Practical Obstetrics (3rd & 4th)	Mr. Hicks (Oct. and Jan.)	—	—	Tu	—	—	—	—
Chemical Physiology (Jan.) (2nd)	Dr. Pembrey, Dr. Forsyth & Dr. Spriggs	11	—	—	—	—	Fri	Sat
Biology and Botany (pre. sci.)...	Dr. Stevens	2	—	—	W	—	Fri	—
Chemistry (1st and pre. sci.) ...	Dr. Wade	12.15	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Wade, Mr. Ryffel and Mr. Ball ...	10-12	—	Tu	—	Th	—	—
Advanced Practical Physiology (3rd)	Dr. Pembrey	11	M	—	W	—	—	—
Practical Medicine (3rd) ...	Dr. French and Dr. Barber	12.30	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Ball ...	12	M	—	—	—	Fri (2)	—
Chemical Physics (1st)	Professor Reinold	2	—	—	—	—	Fri	—
Practical Surgery (3rd)	Mr. Thompson	12	—	—	W	—	Fri	—
Physiology (2nd)	Dr. Pembrey (Oct.-Dec.)	10	M	—	W	—	—	Sat
Clinical Medicine (3rd & 4th) ...	The Physicians	1	—	—	—	—	—	Sat
Surgery (3rd)	Mr. Lucas and Mr. Golding-Bird ...	9·30	M	—	W	Th	—	—
Clinical Surgery (3rd & 4th) ...	The Surgeons	1.30	—	—	W	—	—	—
Elementary Biology (1st) ...	Dr. Stevens and Mr. Turner	2	—	—	W	—	Fri	—
Mental Physiology (Oct. & Nov.) (3rd & 4th)	Dr Craig	2	M	Tu	—	Th	—	—
Morbid Anatomy (3rd & 4th) ...	Dr. Fawcett and Dr. Beddard	2	M	Tu	W	Th	Fri	Sat
Medicine (3rd)	Dr. Taylor and Dr. Hale White ...	4	M	—	W (3)	—	Fri	—
Ophthalmic Surgery (Jan.) (4th)	Dr. Brailey	4	—	—	W	—	—	—
Public Health (Jan.) (4th) ...	Dr. Sykes	4	M	—	—	—	Fri	—
Anæsthetics	Mr. Rowell (Dec.)	—						
Dental Surgery and Pathology...	Mr. Wynne Rouw	4	—	—	—	Th	—	—
Metallurgy	Dr. Wade	4	M	—	—	—	—	—
Practical Dental Metallurgy ...	Mr. Hopson (Jan.)	3.30	—	Tu	—	—	—	—
Dental Anatomy & Physiology...	Mr. Maggs	4.30	—	—	W	—	—	—
Dental Mechanics	Mr. Lewin Payne (Oct.–Dec.)	4	—	Tu	—	—	—	—
Practical Dental Mechanics ...	Mr. Pillin (Jan.)	2.30	—	—	—	—	Fri	—

SUMMER SESSION. MAY—JULY.

†	Lecturers.		Days.					
Medical Jurisprudence (3rd & 4th)	Sir Thos. Stevenson	10	—	—	W	—	Fri	—
Midwifery (3rd)	Dr. Horrocks and Mr. Targett	9	—	Tu	W	Th	—	—
Diseases of Women	Dr. Horrocks and Mr. Targett	9	—	—	—	—	Fri	—
Pathology (3rd)	Dr. Pitt	9	—	—	—	—	—	Sat
Mental Diseases (3rd)	Dr. Craig	9.30	M	—	—	—	—	—
Bacteriology (May & June) (4th)	Dr. Eyre	4	—	Tu	—	—	Fri	—
Practical Obstetrics (3rd) ...	Mr. Hicks	—	—	Tu	—	—	—	—
Biology and Botany (pre. sci.) ...	Dr. Stevens	2	—	—	W	—	Fri	—
Physiology (2nd)	Dr. Pembrey	9.30	M	—	W	—	—	Sat
Histology (1st)	Dr. Pembrey, Dr. Spriggs & Dr. Forsyth	10.30	M	—	W	—	—	Sat
Practical Surgery (3rd)	Mr. Thompson	12	—	—	W	—	Fri	—
Practical Medicine (3rd) ...	Dr. French and Dr. Barber	12.30	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Ball ...	12	M	—	—	—	Fri (2)	—
Clinical Medicine (3rd & 4th) ...	The Assistant Physicians	1.30	—	—	W	—	—	—
Clinical Surgery (3rd & 4th) ...	The Assistant Surgeons	1.15	—	—	—	—	Fri	—
Morbid Anatomy (3rd & 4th) ...	Dr. Fawcett and Dr. Beddard	2	M	Tu	W	Th	Fri	Sat
Materia Medica (2nd)	Dr. Bryant	4	M	—	W(3)	—	Fri	—
Anæsthetics	Mr. Rowell (June)	—						
Operative Dental Surgery ...	Mr. Parfitt	9	—	—	—	Th	—	—
Chemistry	Dr. Wade	12.15	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Wade, Mr. Ryffel, and Mr. Ball ...	9	—	Tu	—	Th	—	—

* No effort has been made to include the many demonstrations or practical work.

† The numbers in this column refer to the years in which this course should be attended.

The Sciences.

Anatomy and the Dissecting Room.

How to begin Work.

THE first working day spent at Guy's Hospital is always a memorable event. There is a feeling of strangeness, which is quite natural. We are but vaguely conscious of what is to be done, and blissfully ignorant how to set about it. The very names of the subjects we have been told to learn convey no meaning, and the school buildings, with their various class-rooms and theatres, are an unexplored country through which we travel as in a maze.

For the help of the new men, it is proposed to give such instructions as they may need in beginning the work of their first winter session at Guy's. It will be assumed that they have already decided what the general course of their study is to be; that is briefly, whether they are going in for the Preliminary Scientific Examination of the London University or not. Information on these matters is readily obtained at the Medical School Office, and any student who is not clear in his mind as to the examination he has to prepare for, should read carefully page 73 in "the green book."

After the first few days men soon become familiar with the work, and learn from one another. But at first they have made no acquaintances, and all around them are strangers alike.

Under the Five Years' Regulations of the Conjoint Board, the first object of the student (entering, for instance, in October, 1904) is to pass the examinations in Chemistry and Biology, as failure to complete these by the following March (*i.e.*, 1905) must postpone the date at which the Second Conjoint should be passed (*i.e.*, April, 1906), *vide* par. 6, p. 389, so that students are advised, unless they have passed either one or both of the above subjects before entering the hospital, or are unusually well versed in the subjects for these examinations, to postpone dissecting until one or both (Chemistry and Biology) have been completed.

What follows refers, therefore, only to those who intend to undertake their dissections at once.

Monday, October 3rd.—There is no actual work done on this day, but each student who is ready to dissect (*vide supra*) should pay his fee, *vide* par. 2, p 389, for anatomical material in the Medical School Office, and take the receipt across to the dissecting-room and present it to the demonstrators. He should then study the Red Book—which contains the rules of the dissecting-room—and purchase the necessary instruments and the other paraphernalia therein indicated. Any spare time is well spent in learning where the museums, class-rooms, and theatres are situated. The ground plan at the front of the "green book" will show them at a glance, and serve as a very efficient guide.

Tuesday, October 4th.—At 9 o'clock in the morning the start is made, and we get our first introduction to the duties of hospital life at a lecture by Mr. Dunn in the anatomical theatre, and at 12 o'clock a demonstration is given to all first year's men by the Senior Demonstrator (Mr. Fagge) in the small theatre attached to the dissecting-room, both of which every new student is expected to attend.

To find a "Part."

Look down the list of names on white cards which are suspended upon the wall of the dissecting-room opposite each subject or body. Be careful to take the proper side (right or left) which is allotted to you. If you fail to find your name on these cards, make yourself known and report the fact to one of the demonstrators present, who may be recognised by his white coat. The next thing is to obtain a bandage and cloth from the attendant (Hancock), who will be found in a room outside the dissecting-room. With these the "part" must be covered up at once to prevent the skin from drying. If the "part" is a limb, bandage it firmly from the hand or foot upwards as far as the bandage will go, and cover the remainder with a cloth, *but be careful to leave the metal ticket exposed to view.*

The Requisites for Dissection.

The following articles are essential, and must be purchased at once:—

a. Case of instruments. This should contain at least four knives, forceps, sissors, hooks, needle and blowpipe, and can be obtained from Hancock, the dissecting-room attendant, or at Messrs. Down Bros., of St. Thomas's Street; Messrs. Arnold & Sons, West Smithfield; Messrs. Maw, Son & Sons, Aldersgate Street; or Messrs, Allen & Hanbury, Plough Court, Lombard Street. Price about 15s. to 20s.

b. Books. These are obtainable at Grattan's in the Borough, next door to the post office. It is advisable to obtain *Cunningham's Practical Anatomy* (2 vols. 10s. 6d. each) for use in the dissecting-room, which show how to proceed and what is met with in the course of dissection; *and* one at least of the standard text-books, viz., Gray, Cunningham, Morris, or Quain's Text Book. The inquirer will hear their merits compared at the introductory lecture and demonstration; if still in doubt he should consult personally one of the demonstrators, and take with him any old text-book he may possess for inspection and advice as to its use.

c. An apron and sleeves for the sake of protection and cleanliness. These are sold by Hancock. Any old coat may be worn under them. Instruments, books, apron and coat must be safely put away in a locker provided for the purpose; the key is obtained by making a deposit of 5s. at the Medical School Office. During the day hats and coats are kept at a special cloak-room near the dissecting-room.

d. A disarticulated skull and a half skeleton. (*See below*).

With regard to all the necessary articles mentioned above in a, b *and* d, *it is well to point out to new students that many men who have just completed their anatomical studies may wish to dispose of some of the above articles*

second-hand, and new students may obtain information about, and details of such things, to be bought from the Librarian or Hancock, with whom such things are usually lodged. Before completing any such purchase it is always best to make sure that the books are of the last edition published and that the instruments are reliable, points on which any of the demonstrators will gladly give advice.

How to Dissect.

The instructions given on this point in the text-books are by no means clear to one who has never done any dissecting in his life, and who does not know the meaning of half the scientific words in which the directions are given. He finds quite a new language in use, and no translation of it in the margin. Thus, he is told to "make an incision," instead of "cut"; to "reflect the integument," for "turn back the skin"; "anterior and posterior," instead of "in front and behind." Not a little of the difficulty and dulness attaching to anatomical description depends on the need of a mental translation of the language in which they are written.

To deal fully with the skilful act of dissection is unnecessary here, and we will merely give such short directions as are needful for the work of the first two or three days. The objects of dissection are—firstly, to educate the sense of touch, and to teach the hand and the eye to work together in delicate manipulation; and secondly, to enable the student to see and handle the different structures that he reads about in his books. It is most decidedly not the object of dissection to lay bare the bone in the middle of the "part" in the shortest possible time. That is butchery, not dissection. The following advice, then, may be given :—

1. Take your book (Cunningham) by which you intend to dissect and read over the pages giving directions for the skin incisions to be made in that particular part you are about to dissect.

2. Cut through the skin along the lines given in the books.

3. Turn back *the skin only*, leaving the fat upon the body. This is done by holding the knife obliquely with its edge towards the skin.

4. Take away the fat carefully without damaging the dense white layer which covers the muscles.

5. Clean the surface of the muscle. To do this make the muscle taut by moving the limb, or pulling on it with hooks; then with the point of the knife clear away everything covering the muscle by working *with* its grain or fibre, *not* across the fibres.

6. Before taking any fresh step in your own dissection get a notion of the arrangement of the parts you are going to expose, either from another man's part, or from the "pickle-room," or wax model museum preparations. *Most important of all, never remove any structure until you have obtained a good mental picture of it, and have also read in your book the description of it, and have satisfied yourself you know it.*

7. Work very slowly at first. To turn back the skin carefully is quite enough to occupy the first day's work-time.

8. Cover the "part" up with a cloth before leaving it for the night.

The Red Book containing the rules of the dissecting-room will be found to contain a lot of useful information, which we give in full below, and should be read with care, and then kept always at hand.

Osteology

Usually considered a very dry subject; hence commonly studied in a stuffy museum after a heavy lunch with—the usual result. Like other branches of anatomy it must be learned practically—by handling the bone, reading the description of it, and noting the various marks upon it, each one of which has its meaning. In order that the bones may be studied at home as well as at the hospital, it is very important that each student should possess them. Half sets of osteology, that is, the bones of one side of the body with the spine and head, can be obtained second-hand at a very moderate outlay, and if carefully used they will at the end of the course readily fetch half the original cost, or even more. Some very useful half-sets (second hand) are to be seen at Messrs. Millikin & Lawley's, 165, Strand, W.C., price 30s. If these are disposed of at the end of the second Conjoint examination for half the price, it follows that the immense advantage of having the bones always at hand while preparing for the examinations is obtainable at the expense of a few shillings.

In selecting a half-set of osteology it is as well to have the guidance of a fellow student who is familiar with them. See that the half-set is complete, and that each bone is of the *same* side. Avoid "the nice white bones," which dealers always charge extra for, and choose the rougher, better marked and dirtier ones. The preparation which makes them white, does away with many of the marks and ridges which have to be studied. With regard to the disarticulated skulls, try the separate bones and see whether they fit into each other properly, as it is not uncommon to find skulls offered for sale, the bones of which have come from different subjects, and hence cannot be articulated.

It may be necessary to caution men against neglecting the subject during their first year: they will find the second year's work quite heavy enough as it is, and moreover may suffer the mortification of being spun in the school elementary anatomy examination at the end of the first winter session, if they neglect the bones in their first month's work.

Rules of the Dissecting Room.

1. All first and second year's students, and all those senior to the second year, who have not passed the Second Conjoint Examination, are expected to attend in the dissecting-room on the first day of the Winter Session, between the hours of 1 and 4 p.m., or on the second day between the hours of 10 a.m. and 12 noon. Each student must bring with him a voucher indicating that he has paid the special fee for material, which voucher must be handed to the demonstrator in order that the student's name may be enrol ed in the appropriate class list.

2. The fee for material (which should be paid in the Medical School Office on or before the first day of the Winter Session, between the hours of 10 a.m. and 1 p.m.) is—

For each academic year :—

First Year's Students	25/–
Second Year's Students	
Students Senior to the Second Year but not yet through the Second Conjoint Examination	

For each three months :—

Students who have passed the Second Conjoint Examination and are preparing for any later examination	10/6
Students for the L.D.S. Examination only	

3. The senior demonstrator (Mr. Fagge) will meet the first year's students on the second day of the Session at 12 noon, and give them a demonstration to initiate them into the work of the dissecting-room. Immediately after this demonstration parts will be allotted to students.

4. On the following day the bone classes, which are held by Mr. Rowlands and Mr. Turner, begin. Every student is advised to purchase a half skeleton and to bring to the class the bone or bones which will form the subject of the demonstration. Regular attendance at these classes is compulsory until a student has passed in Elementary Anatomy. A student attending the class that is studying (A) or (B), in Rule 8, will be allotted a part corresponding with the work of the class.

5. The senior demonstrator will meet the second year's students on the third day of the Session. The Second Year Class demonstrations given by Mr. Rowlands and Mr. Turner begin early in the following week.

6. No student shall be enrolled in the Second Conjoint list or allowed to begin dissecting as a second year's student until he has passed in Biology and Chemistry at the First Conjoint Examination and the School Examination in Elementary Anatomy.

7. The notice-boards in the dissecting-room should be examined daily throughout the Session. Here will be found class lists, notices of allotment of parts, announcements of vacancies for prosectors, arrangements for examinations, etc., and notices of alterations in standing arrangements. Every student's name should appear in one of these class lists, and any student failing to find his name should at once inform one of the demonstrators.

8. A written examination in Anatomy is held just before the Christmas vacation. Every first year's student, whether medical or dental, is required to attend and to answer the questions on one of the following groups :—

(A) The bones and ligaments of the head, and the bones, ligaments and muscles of the upper extremity ; or

(B) The bones and ligaments of the spinal column and thorax, and pelvis, and the bones, ligaments, and muscles of the lower extremity.

Every second year's student is required to attend and to answer questions on—

The muscles, tendons, bones and ligaments of the whole body ; and one of the following groups—

(α) The entire anatomy of the upper extremity and of the head and neck, including the brain and spinal cord ; or

(β) The entire anatomy of the lower extremity and of the abdomen, pelvis and thorax ; or

(γ) (*if he is taking the L.D.S. only*) The entire anatomy of the head and neck, excluding the brain.

9. The dissection of all parts allotted in October and November must be completed before Christmas, and on the second day after the recess new parts will be allotted, priority being given as far as possible to those students who showed themselves most painstaking in their previous work. A first year's student who, before Christmas, studied sub-division (A) in Rule 8, will now study sub-division (B) : but in addition every student should, in this his second part, try to master as much as possible of the vessels, nerves, etc.

10. A school examination in Elementary Anatomy on the bones, ligaments, and muscles of the whole body, is held four times a year, in March, July, October and December ; this must be passed by everyone before he is allowed to commence the recognised period as a "second year's" student.

11. The senior demonstrator holds (i.) classes throughout the Winter and Summer Sessions for students preparing for the First F.R.C.S. and M.B. Examinations of the various universities in general advanced Anatomy and in Embryology. (ii.) Revision Classes before each of these Examinations. (iii.) Revision Classes for students who, though they have completed their second year, have not yet passed the Second Conjoint Examination.

12. Every student is advised to carry with him when in the dissecting-room and demonstrating theatre a pocket note-book and a set of coloured chalks.

13. Every week the dissections are examined systematically by the demonstrators, and marks are allotted. Each student's diligence in the dissecting-room is taken into account in subsequently recommending to appointments in the wards.

14. A test examination is held three weeks before each Second Conjoint Examination. Attendance at this examination is compulsory on all those who wish to present themselves for the Second Conjoint Examination.

15. Particulars of the examination for the Michael Harris, Arthur Durham, and Hilton prizes, and for the prizes for General Proficiency will be found in the Prospectus of the Medical School, which may be obtained in the Medical School Office.

16. About twelve prosectors to the lecturers on Anatomy are appointed annually (and from time to time a prosector to the Royal College of Surgeons of England) from among those students who have shown themselves most diligent in the dissecting-room. Notices inviting

applications for these appointments are posted in the dissecting-room.

17. The metal ticket attached to each part must on no account be allowed to come off nor to be covered up by the bandage that each student should apply to his part (if a limb); neglect of this rule renders the part liable to be forfeited. Apron and sleeves (2s. 6d.), bandages, cloths, air-pump, ointment, carbolic lotion, etc, can be obtained from the dissecting-room porter.

18. No muscle, tendon, nerve, artery, or large vein, should be cut through, if by hooking it aside it is possible to reach and clean the parts lying on its deep surface.

19. No limb must be removed from the trunk except by one of the demonstrators or assistant demonstrators, nor in any circumstances must any part of a subject be removed from the dissecting-room.

20. Except when the student responsible for a part is actually at work upon it, each part must rest constantly on the table of the subject to which it belongs. Neglect of this rule renders the part liable to be forfeited. When a student considers he has finished the part, he must report the fact to one of the demonstrators.

21. The subject is divided into five parts on each side :—

1. The Head and Neck and Spinal Column.
2. Upper Extremity and Muscles connecting it with the Trunk.
3. Abdomen, with the Perinæum and interior of the Pelvis.
4. Lower Extremity.
5. The Thorax, the dissection of which is not to commence until the fourteenth working day.

22. Students are not permitted to exchange or dispose of their parts, either before or after the commencement of dissection.

23. Any part, the dissection of which has not been begun within twenty-four hours from the time when the body is placed in the dissecting-room, is liable to forfeiture. If a student is unable to continue the dissection of the part which he has already begun, he must give notice in writing to one of the demonstrators, who will make arrangements for its disposal. The demonstrators will also dispose of any part, the dissection of which has been discontinued without their sanction for more than two working days.

24. The subject when brought in will be placed in the supine position, and will so remain during nine working days. On the tenth day a majority of the students engaged upon it, and on the fourteenth day any one of them, may have it turned into the prone position. Five days later it may, if the majority so desire, be turned back again; and after six days in the prone position any one of the dissectors may have it turned back. The time for the dissection of the perinæum is before 11 a.m. on the first ten days, and neither for this purpose nor for any other must the subject be turned out of the position indicated in this rule.

25. The dissecting-room is open from 9 a.m. till 4·30 p.m., except on Saturdays, when it is closed at 2 p.m.

26. On applying at the Medical Office a locker may be obtained for a deposit of Five Shillings (which will be returned when the key is given up, provided that the locker is uninjured).

DENTAL STUDENTS.

A dental student, on entry, must pay the fee (10s. 6d.) for material at the Medical School Office, on October 3rd, between 10 a.m. and 1 p.m., so that a part may be allotted to him at the earliest opportunity. He should obtain a copy of the rules of the dissecting-room, and study those paragraphs which specially concern him. He should be careful not to miss the demonstration given by Mr. Fagge to first year's students, on Tuesday, October 4th, at 12 noon.

It is very important for first year's dental students to commence their anatomical studies without delay. During their first six months they should dissect the upper and lower extremities, and attend the bone classes held by Mr. Rowlands and Mr. Turner throughout the winter and summer sessions. They should pass the school elementary anatomy examination at the end of their first six months if possible, or failing this, not later than nine months from their entry at the hospital. The subjects of this examination are :—

1. All the bones and ligaments.
2. The muscles and fasciæ of the upper and lower extremities.

Having passed the elementary anatomy examination, dental students are allotted a head and neck, in which they are expected to dissect, besides the muscles and ligaments, the vessels, nerves, and other soft parts, and also to acquaint themselves with the anatomy of all the special regions of this part, *e.g.*, the orbit, mouth, pharynx, etc.

Mr. Rowlands holds anatomy classes for these students, throughout the winter session, in the dissecting-room theatre, on Thursdays, at 1.30 p.m., and a test examination is held on the work at the completion of the dissection and the course of demonstrations. It will be agreed that the second dissection is even more important than the first, and it is well to realise that, as the work done by each man is noted and marked every week by Mr. Rowlands, and men are only signed up for the necessary session's work when these marks are satisfactory, that careful and conscientious dissection, punctual attendance at demonstrations, and industrious reading up of all the work, must be begun as soon as the dental student enters the dissecting-room, and continued until the subject is mastered.

It is very essential that the study of anatomy, physiology, and surgery should be prosecuted energetically from the outset, thus obviating the necessity for "cramming" these subjects when preparing for the Final L.D.S. examination. Careful and patient dissection is the easiest way to learn Anatomy. An

attempt to "cram" it from books is certain to result in saster.

PHYSIOLOGY.

Physiology, which treats of the working of the healthy body, and forms, therefore, the institutes of medicine and the necessary foundation of any rational mode of treatment of the body in disease, differs from its sister subject, Anatomy, in that it requires much greater intellectual efforts for its acquisition, and a more thorough preliminary training for the comprehension of its doctrines. Physiology consists chiefly in the application of the natural laws elicited by the researches of physicists and chemists to the explanation and description of the phenomena occurring in the living body, so that an acquaintance with the chief laws of physics and chemistry forms the necessary basis for the study of physiology. The study of the nervous system, moreover, requires some knowledge of psychology. The difficulty and importance of the subject would seem to indicate, in the clearest possible manner, the necessity of pursuing its study throughout the short space of two years which are devoted to the subjects that are preliminary to the work in the wards. On this account, the student begining his medical studies in October must give all his energies to getting up his biology in order to pass in it at the earliest possible opportunity, and he may profitably combine with the biology lectures and classes the reading of some physiology, such as Starling's *Elements of Human Physiology*, or Halliburton's *Handbook of Physiology*, or the smaller work on the same subject by Foster and Shore. He is advised to attend the physiology lectures at this time, but cannot be "signed up" for them.

By the ordinary student the practical study of the subject included under the heading "Physiology" is begun in the first summer session. During the whole of this session he must attend the classes in Practical Histology. These are held in the students' histological class-room three times a week; each class lasts two hours. Students attending this course must provide themselves with a compound microscope,* certain mounting materials (a list of which can be obtained at the office), and with Schäfer's *Essentials of Histology*, which should be carefully studied in the intervals between the classes. The microscope must have two objectives, a $\frac{2}{3}$-inch and a $\frac{1}{6}$-inch, a nose-piece and an indicator fitted to one of the two eye-pieces. The following makers are recommended: Crouch, Zeiss, Ross, Leitz (English agent, Kanthack), Swift. From any of these latter firms a good microscope, with all necessary accessories, can be obtained for about £7; the microscope from inferior makers is worse than useless, for it is essential that the student should buy an instrument which will be of some use to him in future years, when, as a practitioner of medicine, he desires to examine tumours, urinary sediments, sputum, etc., for purposes of diagnosis.

* The demonstrators will be very pleased to advise any student in the purchase of a microscope. It must be distinctly understood that antiquated instruments, such as those sometimes handed down as an heirloom in a family of doctors, are practically useless.

At the end of the summer session an examination is held in histology. All students who have attended this class must enter for the examination. Only those who pass the examination will be allowed to attend the tutorial classes in physiology held during the second winter session in preparation for the examinations of the Conjoint Board. Those who fail at this examination will be examined in the following session.

During the first summer session and the first half of the second winter session, the student should attend regularly the lectures on physiology held three times a week, on Mondays, Wednesdays, and Saturdays at 10 a.m. During the same time those who have passed the histology examination at the end of the previous session should attend the tutorial classes held by one of the demonstrators throughout the session. At the same time he should read up the subjects in some text-book such as Starling's *Elements of Human Physiology*, or Halliburton's *Handbook of Physiology*.

During the winter session, *i.e.*, from January to March, students must attend the classes in practical physiology, which are held on Friday and Saturday mornings from 11 to 1. From October to Christmas physiological chemistry is worked at in the room devoted to that subject. While attending this class, they are recommended to read up the subject in *Practical Physiology* (published by Arnold) which is used in the practical work. From January to March the class is held in the histological Laboratory, where the student becomes practically acquainted with physiological apparatus, and performs simple experiments.

Students who have been diligent in following this course of studies will be ready to enter for the second Conjoint examination at the end of this session. Shortly before this examination, a test examination is held by the demonstrators in order to judge of the fitness of the candidates. Those who fail to pass the second Conjoint at this time must attend the revision classes held by the demonstrators during the two or three months preceding the July and January examinations of the Conjoint Board.

Certain modifications in this course of studies is necessary for those who are going up for the M.B. of London or other Universities. Having passed their preliminary scientific before entering, they are free from the study of biology during their first winter session. They should therefore attend the physiological lectures during this session, at the same time studying the subject in Starling's *Physiology*. In their first summer they attend the histology classes, and read Schäfer's *Essentials of Histology*. During their second winter, they should attend the class in advanced practical physiology, which is held twice a week, each lesson occupying between two and three hours. During this session they are recommended to read up the subject in Stewart's *Manual of Physiology* and Bunge's *Physiological Chemistry*, using *Practical Physiology* in the advanced practical work. This class should also be attended by candidates for the first F.R.C.S. examination, although in their case attendance

may often be profitably postponed until the third winter session. The reading for this examination is similar to that required for the Intermediate M.B. of London.

Those who are desirous of obtaining honours at the Intermediate M.B. should supplement the course of reading already indicated with original papers in the *Journal of Physiology* and with parts of Schäfer's *Text-book of Physiology*. Such students will also find parts of Foster's *Physiology* extremely useful and suggestive. University students should also attend the lectures given on Physiology at the London University.

Revision classes are held by the demonstrators during the two months preceding the first F.R.C.S. and first M.B. examinations for the special preparation of candidates for these examinations.

List of books recommended:—

FOR COLLEGE MEN.—Schäfer's Essentials of Histology; Starling's Elements of Human Physiology, or Halliburton's Handbook of Physiology; Practical Physiology, published by Arnold.

FOR UNIVERSITY MEN.—Stewart's Manual of Human Physiology; Bunge's Lectures on Physiological Chemistry; Embryological parts of Quain's Anatomy.

BIOLOGY.

The course of instruction for the Preliminary Scientific of the London University M.B. examination consists of lectures which are given on Wednesday and Friday at 10.30 a.m., and on Thursday at 4 p.m., and of demonstrations and practical work on Wednesday and Friday mornings 11.30 to 1.30, and on Wednesday afternoons 2 to 4 p.m. The Biological Laboratory is open at all times between 9.30 a.m. and 5 p.m., so that students may revise their work and complete any part they may have been unable to finish in the regular hours. The first lecture will be given by Mr. Assheton on Wednesday October 5th at 10.30 a.m. in the Anatomical Theatre. There will be an exhibition of microscopes, dissecting instruments, and books, such as will be necesssary for the course in the Biological Laboratory after the first lecture. Students are strongly recommended not to buy anything until they have seen the exhibition, or consulted the lecturer or demonstrator.

The course of instruction for the Biology examination of the Conjoint Board of the Royal College of Surgeons and Royal College of Physicians, is given in the long room, class-room No. 2, on Wednesdays and Fridays at 2 p.m. The first lecture will be given by Dr. Stevens, on Wednesday, October 5th. The practical class is held immediately after lecture in the same room. The requisite instruments, books, etc., for this course should not be purchased until after consultation with the lecturer, who will advise as to these in the first lecture T.G.S.

CHEMISTRY AND PHYSICS.

It is impossible to acquire a knowledge of Chemistry or Physics without personal and practical contact with the experimental side of these sciences, and Guy's men have, in the roomy laboratories, unusual facilities for this purpose.

Conjoint men entering now should pass in chemistry and physics next Easter, and should therefore attend the lectures in chemistry from October to March (Dr. Wade Tuesday and Thursday at 12.15), and the lectures on physics from October to Christmas (Professor Reinold Monday at 12 and Friday at 2). They must be prepared to devote a large amount of time to laboratory work. The practical classes are held in the chemical laboratory twice a week (Dr. Wade, Mr. Ryffel, and Mr. Ball Tuesday and Thursday from 10 to 12), but students have access to their benches at all hours, and are advised to make free use of this privilege if they wish to make satisfactory progress. The first class of the new session will commence at *10 a.m. on Tuesday, October 4th*, when *all Conjoint Students* should attend the first lecture at 12.15 on the same day. Revision classes are held before the April, January and July examinations; admission to these classes is dependent on the student passing the test examinations in a satisfactory manner.

Dental students under the new regulations are required to go through the same course as the Conjoint men, and to pass the same (Preliminary Science) examination; they should attend the laboratory class at *10 a.m.* on *Tuesday, October 4th.*

Special courses have been arranged for most of the University examinations. Candidates for the Preliminary Scientific (M.B.) examination of the London University attend the same chemistry lectures as the Conjoint men. The physics lectures are continued throughout the sessional year (Professor Reinold, Monday at 12, Friday at 2). The Preliminary Scientific class meets for work four times weekly in the chemical laboratory, (Dr. Wade, Mr. Ryffel, and Mr. Ball, winter and summer, Monday and Thursday, 2 to 4, Tuesday and Thursday, 10 to 12), and twice weekly in the No. 1 physical laboratory (Mr. Ball: winter, Tuesday 2 to 4, Friday 3 to 4; summer, Monday and Thursday 2 to 4); *but students are expected to spend all their spare time in one or other of the laboratories.* It cannot be too often or too strongly urged that reading without laboratory work is mere waste of time. Tutorial classes are held weekly in both chemistry and physics, and are supplemented by revision classes during the term preceding each examination, and by periodical test examinations.

Intermediate M.B. men should begin to work at organic chemistry at once, and should pass the examination in July next. The practical class meets twice weekly in the laboratory throughout the year (Dr. Wade and Mr. Ryffel: winter, Monday and Thursday 2 to 4; summer, Tuesday and Thursday 2 to 4) and is supplemented by lectures, revision classes, and periodical test examinations. A course of experimental lectures for beginners will commence on Wednesday, October 5th, (Dr. Wade, chemical theatre, 2), and will be continued on Wednesdays and Fridays (chemical theatre, 10).

Oxford, Cambridge, or Durham students desiring to work at chemistry should communicate with the demonstrators.

The practical knowledge of toxicology required at degree examinations may be obtained at classes held by Mr. Ryffel during the latter part of the winter and summer sessions.

PRACTICAL PHARMACY, MATERIA MEDICA, DISPENSING.

These subjects are taught in the practical pharmacy class at the Dispensary, by Mr. Finnemore, the Hospital Pharmacist. This course meets the requirements of students preparing for the Conjoint examination in practical pharmacy and the intermediate M.B. Lond. The study of the physical characters, and chemical properties of substances used in medicine, and preparations made from them, and the doses in which they may be given, requires some considerable amount of application and exercise of memory. The instruction given in the class is therefore very practical, and every assistance is given to the student by demonstrations, access to materia medica specimens, and *vivâ voce* examinations, in acquiring a sound knowledge of materia medica. The art of dispensing, the writing of prescriptions, and the method of prescribing drugs, form also part of the instruction given in the practical pharmacy class. During the year there are three courses of three months each, so that the student can enter at the time most convenient to him.

PHARMACY, PHARMACOLOGY AND THERAPEUTICS.

Lectures are given during the summer session in the anatomical theatre, by Dr. Bryant. This course is intended to meet the requirements of students preparing for the third Conjoint examination in Pharmacology and Therapeutics, for the intermediate M.B. and final M.B. Lond., and the third M.B. Cambridge.

MEDICINE.

Medicine lectures are held on Mondays and Fridays at 4 p.m., and Wednesdays at 3 p.m., in the anatomical theatre, throughout the winter session, by Dr. Taylor and Dr. Hale-White. The introductory lecture will be given by Dr. Taylor, on Monday, October 3rd, who will then proceed to discuss "Fever, Contagion and Specific Diseases."

A clinical lecture is delivered every Saturday, at 1 p.m., in the physiological theatre, the first of which will be given by Dr. Hale-White, on Saturday, October 1st. These lectures are held at 1 p.m., so as to enable footballers to attend, and they finish in time for them to catch the 2.23 train to Honor Oak Park.

THE MEDICAL WARDS.

Clinical instruction in Medicine is given in the medical wards to the medical ward clerks and other students who choose to be present, by the physicians, who visit their cases from 2 to 5 p.m., and by the medical registrars in the mornings from 10 a.m. to 1 p.m., and by the house-physicians and clinical assistants to their clerks. There are two male wards, Addison and Stephen, each containing fifty beds, and two female wards, Mary and Esther, containing forty beds and four cots each. Dr. Taylor and Dr. Hale-White divide the beds in Addison and Mary wards between them, and Dr. Pitt and Sir Cooper Perry those in Stephen and Esther wards. On Mondays and Thursdays the wards are visited in the afternoon by all the physicians; on Tuesdays by Dr. Hale-White and Sir Cooper Perry; and on Fridays by Dr. Pitt. The medical registrar, corresponding to Dr. Taylor and Dr. Hale-White sees cases on Tuesday, Thursday, and Saturday mornings. The medical registrar corresponding to Dr. Pitt and Sir Cooper Perry, on Monday, Wednesday, and Friday. Thirty-six medical ward clerks are appointed every three months, and are eligible for reappointment at the end of this time for a further period of three months, the extension being given to those who have shown the most care and diligence in the discharge of their duties.

Case-taking.—Reports are made by the medical ward clerks on all the cases admitted to the wards, under supervision of the medical registrars, who instruct the clerks in the mornings in the method of case-taking and the physical examination of the patients. To each physician is appointed a clinical assistant, who, with the registrars, superintends the writing of the reports and helps the clerks in any special examination of blood, urine, etc., which may be necessary.

The reports are written on special sheets, kept for the purpose in each ward, and the name, age, address, etc., of the patient should be carefully filled in, as well as any previous admissions into the hospital. In the latter case the abstract of the old report should be copied into the new report. Details as to how to find an old report will be found posted in the medical registrars' room. Ward clerks should always make brief abstracts of the case at the end of the report, and in case of death the post-mortem abstract should be copied in, and when the report is finished it should be handed to the clinical assistant, who eventually sends it to the medical registrar. Where possible it is as well to put in the report what the physician said about the case, and especially his diagnosis, but clinical teaching on the disease in general should not be recorded, and great care must be taken to report the physicians accurately.

Classes.—On Thursdays classes are held for all medical ward clerks at 12 o'clock, in the surgical class-room, on the methods of medical diagnosis, and the explanation of physical signs, etc. During the first six weeks of each three months, classes are held in the clinical laboratory for the junior clerks on the practical examination of urines and blood, and the use of the ophthalmoscope, laryngoscope, and other apparatus. During the last six weeks practical classes on ophthalmoscopic work are given by the ophthalmic and medical registrars.

The times of the classes will be found posted in the halls of Stephen and Addison wards.

The Clinical Laboratory (opposite the lift in the medical buildings) is intended for special microscopical examinations of blood, urine, etc. A special bench is reserved for ward clerks in the physiological laboratory, where all chemical tests and analyses in connection with ward work may be carried out.

Medical Instruments. — A laryngoscope, cyrtometer, anæsthesiometer, etc., are kept in Esther ward, and can be had, on application, from the Sister. Instruments for examining blood are provided in Mary, Esther, Addison and Stephen wards.

Tubes for taking cultivations, and pipettes for holding blood for Widal's serum reaction in typhoid fever, can also be had from the Sisters of the wards, but these should not be used except with the help of the clinical assistant, the house-physician, or medical registrar.

It is very important that the clerk should find out the result of the investigations made by the bacteriologist and record it in the report.

A few practical hints.—Never lose an opportunity of examining a patient for yourself, and then find out what you ought to have noticed. It is only by constant practice that you can train your senses to appreciate the signs of disease, and without this skill, mere book knowledge is valueless. Therefore, listen to the normal as well as the abnormal, and get into the way of examining your cases with some method, so that you have an intelligent idea of what you are trying to find out. Although only a few cases are under your immediate care it is not intended that you should limit your observations to these, but you should know well all the cases under your physician, and something about all the interesting ones in the medical wards. To do this, when your own cases have been attended to, you should go round with the registrar, or examine the patients allotted to other clerks, and ask what points of interest there are about each case. Also, when your physician is not going round, attend someone else's clinical instruction, either in the wards or at out-patients. Above all, remember that many of the patients think you to be a "doctor," and treat them as patients, and not as pathological specimens. You cannot be too gentle in an examination of a patient, nor too considerate for the feelings of a sick person. Remember, too, that though the post-mortem room should not be mentioned before patients, yet it is there that you will learn a great deal of medicine, and for you to know your business thoroughly you should never miss an opportunity of seeing the organs whose condition you have tried to make out during life.

As regards reading, Taylor's or Osler's Medicine are the best books, and at first you should read up your own cases and then others as you come across them. Hutchinson and Rainey's Clinical Methods, or Gibson and Russell's Outlines of Physical Diagnosis will also help you very much. M. R.

PATHOLOGY.

The large number of courses of instruction in Pathology given in the school leads to some uncertainty in the student's mind as to the order and period of the curriculum in which they should be taken. Pathology is one of the few good things of which it is impossible to have too much, and probably the best advice that can be given to a student who has passed his second conjoint or intermediate M.B. is to take the instruction in pathology which is offered to him as early and often as possible. Most of the instruction in pathology is given in the early morning, so that it shall clash as little as possible with work in the wards, and it is rarely advisable to postpone attending a course till the time arrives, which many seem to expect but fortunately seldom reach, when ward duties shall be less exacting than they are at first. A man who leaves the dissecting-room in April should begin to attend Dr. Pitt's systematic lectures on pathology in the following summer session (Anatomical Theatre, Saturdays at 9), where he will be introduced to the great principles underlying pathological processes, and will learn something of the theories of disease, which will enable him to understand the facts revealed to him in the post-mortem room. He should remember that this course of lectures is not completed in one year, and that if he attends the lectures for three consecutive years he will each time hear different subjects treated of. If it is in the summer session that a student is released from his anatomical studies, he should begin to learn pathology at the winter demonstrations (Dr. Fawcett and Mr. Steward, Monday, Wednesday and Saturday, 9.15, in class-room No. 2). Here he will be introduced to the treasures of the pathological museum. Selected specimens will be brought from the shelves of the museum for his inspection, and the effects of pathological changes upon the various organs of the body will be demonstrated. The subject is roughly divided into medical and surgical pathology, two days a week being devoted to the former and one to the latter. The whole course occupies two years. At the end of each half-hour demonstration on museum preparations, a *vivâ voce* examination is held on typical recent specimens collected from the post-mortem room and operating theatre.

Valuable as is the instruction afforded by these systematic lectures and demonstrations, they must on no account be allowed to take the place of the daily demonstrations of Morbid Anatomy (Dr. Fawcett and Dr Beddard, 2 p.m.) in the post-mortem room. Here a student gains information on the relative distribution of morbid processes throughout the body, and learns to verify the accuracy of his observations at the bedside. No ward clerk must on any account neglect to follow the fatal cases to the post-mortem room, and throughout a student's career there is probably no more profitable way of spending an afternoon unappropriated to routine duty than in watching post-mortem examinations. Although several of the examining boards require students to have held the appointment of post-mortem clerk, yet all do not do so, but nevertheless it is a post

not to be omitted if possible. The man who misses the opportunity while he is at the hospital of becoming acquainted with the many difficulties that may be encountered in making a post-mortem is sure to regret it afterwards.

The practical use of the microscope in solely pathological problems should be learnt as early as possible. With this object the course of Microscopical Pathology (Mr. Bellingham Smith and Dr. Eyre, Tuesday and Friday at 9, in the New Histological Laboratory) should be attended in the first winter session after the student gets into the wards. Here he will gain his first instruction in practical Bacteriology, which he will have constant opportunities of making use of in the wards. Here he will also amplify the knowledge he has already acquired, in the course of Normal Histology, of section cutting and staining, and have demonstrated to him the microscopical appearances of tumours and diseased tissues. A man cannot often find time to attend this course more than once, but he should attend it early in his career and work hard to learn enough about technique to enable him to afterwards examine specimens that constantly come in his way while holding senior appointments. Morbid histology and bacteriology are very engrossing studies, and many good men fight shy of them on account of the amount of time they fear they will "waste" over them. But a man of method can generally find a good many spare moments to devote to this work without seriously interfering with his reading, and he who acquires the hobby will find it a useful one to ride when he has accomplished his examinations and is waiting for patients.

It should be noted that special classes to meet the requirements of Cambridge and other university students have recently been started, in which Dr. Beddard goes over the main points of General Pathology.

BACTERIOLOGY.

The compulsory course in Bacteriology forms part of that in microscopical pathology. As in previous years, the first two months will be occupied with this subject. The rudiments of the science are taught; the methods of staining sputum, pus, etc., to demonstrate bacteria; the methods of collecting morbid products for bacteriological investigation; in fact, the technique of the examinations which can be undertaken in connection with the ward work.

A course is also held in the Bacteriological Laboratory during the months of November and December, covering practically the same ground, and is largely intended to meet the requirements of qualified men and students other than Guy's men.

Two optional systematic courses, each of about two months' duration, are held, beginning in January and May respectively, and especially intended for Final M.B. men and candidates for the various diplomas in Public Health. The course consists of lectures and demonstrations of morbid secretions and excretions, the bacteriology of water, air, and food; pathogenic protozoa, etc.; the study of recent work on susceptibility, immunity, etc. The students are instructed in the practical details of media making, culture, staining methods, etc., and they individually examine the more common pathogenic and non-pathogenic bacteria.

SURGERY.

Lectures are held three times a week, on Mondays, Wednesdays and Thursdays, at 9.30 a.m., by Mr. Lucas and Mr. Golding-Bird.

Mr. Golding-Bird for the first-part will lecture on "General Surgery," commencing on Monday, October 3rd. Clinical lectures will be given on Mondays, at 1.30 in the physiological theatre, by the surgeons. Mr. Lucas will commence on October 3rd. After November 10th the day for the clinical lecture will be changed to Wednesday.

Mr. Steward, six weeks before the final Conjoint examinations in January, April and July, will hold "Revision Classes." Only those desiring to present themselves for examination are expected to attend.

Sir Alfred Fripp will hold a course of "Operative Surgery" for final M.B. and Fellowship men in October, of which further notice will be given. The course for the requirements of the Conjoint Board will be held in January, 1905, and the fee of 10s. 6d. should be paid not later than December 19th. Names of students desirous of attending the M.B. course, should be left at the Medical Office *before* the end of September. Mr. Brailey will lecture during January to March on "Ophthalmic Surgery," on Wednesday, at 4 p.m., in the ophthalmic operating theatre. The lectures must be attended after passing the second Conjoint examination before admission to the final Conjoint.

Mr. Jacobson holds a Clinical Class on Wednesdays at 2 p.m., in the large operating theatre, for the benefit of candidates for the Conjoint and other examinations in surgery. The classes have proved since their commencement a marked success, and should be attended by all students entering on their final examinations in surgery. We are informed, on good authority, that at least one other member of the surgical staff intends to hold similar classes during the winter session.

THE SURGICAL WARDS.

In the surgical wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write full accounts of the cases admitted to the wards. He will find, however, that by paying attention to the advice we give him, that his difficulties will be found to be anything but insurmountable.

Being the junior appointment in the hospital, there is a tendency in the minds of some, and a little more than a tendency in the minds of others, to belittle the post. That is unjust, and is the result of ignorance of the real functions of the surgical clerk. What the medical clerk is to the medical side, the surgical clerk is to the surgical side. The post is junior in point of time, but does not necessarily carry with it any stigma of inferiority. Their duties are identical: the preparation of the permanent hospital records of the cases admitted to the wards. What difference there is consists in this: the machinery of the medical side is less complicated than that on the surgical; whereas the whole of the work in the medical ward falls on the clerk, in the surgical wards it has been found advisable to specialise and to separate—for the sake of greater proficiency—the duties of clerking and dressing. This separation has thoroughly been justified by the results, the chief difficulty being the dependency of the clerk on the dresser for many details of importance. Dressers should, therefore, remember that from them the hospital expects such assistance as will render the reports as complete as they can be made. On the clerk, however, rests the responsibility, and the excellence of his reports is a sure indication of smooth working and mutual assistance in the firm to which he belongs.

The most important point for a clerk to remember is that in after years cases and not book work will form his mainstay in practice, and that he cannot too soon get the clinical entity and results of treatment into his memory.

The appointment of an overseer to each firm of clerks in the person of a clinical assistant in the surgical wards is of inestimable value, primarily to the clerks, secondarily to the whole firm. The clinical assistant should be the immediate "ear" of all his clerks, to instruct them of their duties in the wards, also relieving the surgical registrar of many details in the filling in omissions of the reports of his firm.

We do not wish to exalt the clerk unduly but to insist merely that in his work the same care and attention to detail, the same knowledge of surgery and human nature are as necessary as in other appointments. Let him bear in mind that to him is given by the hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. The importance of good careful work by the clerks cannot be over-estimated. In the nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be judged and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary. There is no loss of dignity sustained in carrying screens to patients, or in the thousand and one small opportunities which present themselves of helping the other workers in the wards.

To the dressers we would submit that the performance of dressing is no part of the clerk's duty, and that it is no kindness to him to request him to undertake what he cannot from his position with good grace refuse, and what nevertheless he is unfitted to do.

The work of the firm, as a whole, should be the interest of each individual member of it. Pride should be taken not only in its splinting and dressing, but also in its reporting. A good house-surgeon and a good dresser will see that the reports are not below the level of those of other firms, for as they represent the work of the firm the individual members should see that they give a fair and accurate idea of that work. The clerk, aided by the clinical assistant, from this point of view is to be regarded as the mouthpiece of the firm to succeeding generations. The firm should see that he represents it fairly.

It is essential that either the clerk should live within walking-home distance of the hospital, or else get a room for the take-in week. All really good casualty work is done at night, and the periods for seeing the actual Crofting and treatment of fractures is all too short as it is.

The clerk, as soon as he is appointed, should find out from the surgical registrar to whom he is appointed. A few days before taking over the work he should learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. At the present time there is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate temperatures, and pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration rates, and condition of the urine must be included in the notes of every case on admission. The surgical registrar sees every new case with the clerk on the morning after admission, when he expects a history of every case to be ready. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance. The exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work.

He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon house-surgeon, clinical assistant, and dresser. This should be copied into the report as soon as possible. We would impress upon each clerk the value of seeing everything done by the dressers or house-surgeons—the operations, putting up fractures, especially when done at night in take-in week, and this should apply to manipulations on every case under the surgeon, and not only to the cases which the individual clerk has to report—as much may be learnt in this way which otherwise can only later be gathered with much greater effort.

A new departure was made three years ago in the practical surgery classes, which are in the hands of the surgical registrar, who gives four courses a year, each beginning on the appointment of the new surgical ward clerks, and especially designed for their instruction in all matters relating to that appointment.

Lists of the duties appertaining to each appointment are supplied to the students, and these are to be carefully followed out. The hospital not only expects this, but insists on it. We have laid stress so far on the appointment of surgical ward clerk, as it is the first post that the student holds, and because he is so often quite unaware of the objects of the appointment.

He will in time become a dresser, and will by that time have learnt the traditions that underlie his office. He should, before accepting office, have acquired most thoroughly the principles of aseptic surgery, and, on no account, ever depart from them subsequently. Let soap and water be his sheet anchor.

The surgical wards are visited every day by the surgeons and assistant surgeons at 1.45. Notice of operations, which usually takes place on Mondays, Tuesdays, Thursdays and Saturdays, except for emergencies, is posted overnight in the colonnade by the House-Surgeon for the week. The surgeons are assisted at the operations by the dressers, and no others should stand about the well of the theatre, the only exception being the particular ward clerk to the case.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

Finally, we should like to repeat that although specialization has provided a clerk responsible for the drawing up of the hospital records, yet as this report is an account of the work performed by the firm as a whole, it touches the honour of every one in it that the report should be an accurate statement of the work done. The firm should be considered the entity, each separate member of which fulfils his own function, each at the same time being dependent on the others for the smooth, even working of the whole. S. R.

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE.

Accidents and urgent cases of all kinds are admitted by the St. Thomas's Street entrance at any time of the day or night.

THE WARDS.

Medical Wards.—Dr. Taylor (2), Mondays, Thursdays and Fridays. Dr. Hale White (2), Mondays, Tuesdays, Thursdays and Fridays. Dr. Pitt (2), Mondays, Tuesdays, Thursdays and Fridays. Sir Cooper Perry (2), Mondays, Thursdays and Fridays.

Surgical Wards.—Mr. Lucas (2), Mondays, Tuesdays, Thursdays and Fridays at (3.30). Mr. Golding-Bird and Mr. Symonds, Mondays, Tuesdays, Thursdays and Fridays (1.30). Mr. Jacobson, Mondays, Tuesdays, Wednesdays, Thursdays and Fridays (1.30). Operations daily (1.30)

Obstetric Ward.—Dr. Horrocks (2), Tuesdays and Fridays. Mr. Targett (2), Mondays, Wednesdays and Thursdays.

Ophthalmic.—Mr. Higgens (2), Tuesdays and Fridays. Mr. Brailey (2.30), Thursdays. Operations (2), Tuesdays, Thursdays and Fridays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the hospital are as follows :—

Medical Cases.—Dr. Shaw (1), Fridays. Dr. Bryant (1), Mondays. Dr. Fawcett (1), Thursdays. Dr. Beddard (1), Wednesdays.

Surgical Cases.—Mr. Lane (1), Mondays. Mr. Dunn (1), Wednesdays. Sir Alfred Fripp (1), Thursdays. Mr. Steward (1), Saturdays.

Obstetric.—Mr. Bellingham Smith (1), Thursdays and Saturdays.

Ophthalmic.—Mr. Higgens (1.30), Mondays. Mr. Brailey (1.30), Tuesdays and Fridays.

Dental.—The Dental Staff (9) every week-day.

Aural.—Mr. Fagge (1), Tuesdays.

Skin.—Sir Cooper Perry (1), Tuesdays.

Throat.—Mr. Steward (1), Fridays.

Electricity.—Dr. Bryant (12 and 3), Wednesdays.

DENTAL SCHOOL.

The dental student is supplied at the Medical Office with the Prospectus, Standing Orders, Notes on Probationary Work, List of Instruments, Calendar, and Clubs' Union Book.

If these pamphlets are carefully perused, he will become well acquainted with the general arrangements of the school, and the scope of the work upon which he will be engaged during his studentship.

It will first be necessary for him to purchase his instruments at one of the dental depôts, and to satisfy himself that he has been supplied with all of those described in the hospital list.

Probationary work upon the phantom head will occupy the freshman's time for about two months. This operative course is conducted by the staff demonstrators, and is very comprehensive. It includes most of the conservative operations that the student will subsequently perform on patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. If the manipulations upon the dummy are done in a thoroughly sound manner, a capital groundwork of operative dentistry will be acquired. It may be mentioned in passing that too much stress can scarcely be laid upon the necessity of becoming an expert operator, for the public are not slow to appreciate the highest manipulative skill.

The regulations of the Royal College of Surgeons of Eng and require that dental students, who registered on and after January 1st, 1897, shall pass two professional examinations for the dental license. At the first professional examination certificates must be produced *inter*

alia, of having been engaged in the practice of dental mechanics under a registered dental surgeon during a period of three years, and of having manufactured and adjusted six dentures and six crowns.

Inasmuch as it is recommended at Guy's that this examination be passed during the month of May, it follows that the work of the first winter session must be largely devoted to demonstrations, dental mechanics, and lectures.

If a student needs help or advive in his work he should consult the Dean, or a member of the Staff, any of whom will gladly do what he can for the best interests of the student. M.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

New Arrangements for "Take-in."

DEAR SIR,—In the last GAZETTE you certainly put forward the advantages of the new system of taking-in to the medical wards, but, if I may say so, I consider the system also has its disadvantages, more especially from an H.-P.'s point of view :—

1. Every H.P., except the one taking-in, will constantly be receiving new cases, and the care of those which arrive in the night or during his absence will be deputed temporarily to the "taking-in" or "ex-H.P." Thus delay and complications are liable to arise, with possibly serious results in acute cases.

2. H.-P.'s expect to have more or less sleepless nights during the "take-in" week and possibly for some days afterwards, but under the new regulations they will be liable to continual night work unless it be deputed to the H.P. for the week.

3. The direct sense of responsibility to one's own physician will be lessened with regard to the nature of cases taken in. A will suffer for B's mistakes, and *vice versa*, and there will be a tendency towards a less thorough investigation of cases before admittance.

The above are only some of the most obvious objections to the new method, but the great argument against it is that it will probably not achieve what it is intended to, namely, to keep up a regular and constant flow of new cases into every ward. H.-P.'s like to take-in to their own beds, and it will be comparatively easy for the taking-in man to arrange with his colleagues to have their beds full and his empty when the "take-in" begins.

But assuming that some alteration is necessary in the method of taking-in I admit that it is more than foolish to depreciate any proposed alteration unless one has something better to offer. With four H.-P.'s the week might be divided into three; the first H.-P. might take-in on Thursday and Friday, the second on Saturday, Sunday and Monday, the third on Tuesday and Wednesday, and the fourth begin a new week. In this way each ward would stand to get new cases during three weeks in every four, and the privileges of "taking-in" would not be replaced by the disadvantage of "sending in." Further, the H.-P. who did not take-in during one given week could perform the duties of the present ex-H.-P.

Such a method would, I think, meet all requirements and would not be open to abuse, its only drawback would be its comparative complexity.—Yours. etc.,

H. F. BELL WALKER.

21st September, 1904.

Students' Glee Club.

DEAR MR. EDITOR,—May I take advantage of this number of the GAZETTE to inform Freshmen, and to remind everyone else, that the Glee Club will recommence its rehearsals on Friday, October 7th. The Club, in conjunction with the Nurses' Choral Society, produces two concerts during the season, one in December and the other in March. Rehearsals are held every Friday at 5 p.m. in the Governors' Court Room, and combined rehearsals every alternate Friday at 8 p.m. A good start means a good finish, and it is hoped that many new and old members will take advantage of the Clubs' present prosperity to make this season eclipse all previous records. Further details may be obtained, if desired, from the Hon. Secretary, or from any member of the Club.—I am, Yours truly,

R. FELTON, Hon. Sec.

Students' Chapel Choir.

DEAR MR. EDITOR,—The Choir will be resumed on the first Sunday of the session, October 2nd. Members wishing to join can obtain any necessary information from the hon. Secretaries: Mr. H. Garfeld Pearce, Mr. R. J. Gunton Turner, Mr. R. Felton, or the choirmaster, Mr. Henry Taylor.

The Choir is a voluntary one and requires, of each member, attendance at two services, at least, in each month.

Choir practice is held every Friday at 6 p.m. in the Court-room. The first practice will be held on Friday, September 30th, at 5 p.m. Services are held at 11 a.m. and 7 p.m. in the Chapel, which is on the right of the quadrangle at the main entrance to the Hospital. The door of the Court-room is immediately opposite. I am, Yours truly,

R. FELTON, Hon. Sec.

The Christian Union.

DEAR SIR,—Will you kindly allow us to announce through the medium of the GAZETTE, that the Christian Union, a constituent club of the Clubs' Union, holds meetings during the session on alternate Thursdays at 5 p.m., in the Board-room over the Counting-house, preceded by conversazione and tea from 4.30.

The first meeting for this session will be held on Thursday, October 13th, when Dr. P. H. Pye-Smith,

M.D., F.R.S., Vice-Chancellor of the London University, and President of our Union, has very kindly consented to take the chair and give a presidential address.

C. W. G. Taylor, Esq., M.A. Edinburgh, member of the executive of the British Coll. Christian Union, and General Secretary for London will also speak.

We issue a cordial invitation to all Guy's men, and especially to those who have recently joined our hospital.—Yours truly,

GEO. F. STEBBING,
ED. LLOYD.
CLAUD F. FOTHERGILL. } Hon. Secs.

The Physiological Society.

DEAR SIR,—Through the medium of your columns may I be permitted to remind men of the meetings of the Guy's Hospital Physiological Society which are held on alternate Thursdays throughout the Winter Session at 4 p.m. The Annual General Meeting will be held on October 6th, Dr Pembrey in the chair. A special invitation is offered to all men—especially freshmen—who are interested in Physiology.—Yours, etc.,

GEORGE F. STEBBING.

Reviews.

The price of books submitted for review should in every case be stated.

An Index of Symptoms. By R. W. Leftwich, M.D. pp. 399. (Smith, Elder & Co.) 6s. net.

This unique and wonderful compilation has arrived at a third edition, which is even more elaborate than its predecessor. We have a book of reference, in which every disease is indexed under each symptom that has been recorded as occurring therein. As a specimen of condensation it is excellent, and we can imagine nothing more useful to a practitioner face to face with an obscure case, which he cannot diagnose; though of course its very fulness of detail precludes its use as a text-book. We wonder how many people could mention 127 diseases—or rather pathological conditions—in which headache is a prominent symptom, and yet that is the number recorded here. As introduction there is an excellent chapter on Fallacies of Diagnosis, in which we notice, as a useful hint, that, in examining children, auscultation should always be practised *before* percussion. We should like to have seen more distinction drawn between important and unimportant symptoms, though an asterisk is placed against those which are pathognomic. Of course dogmatism is the essence of such a book, and and yet a query would not be amiss after phthisis, when included amongst hereditary diseases, another of which is the enigmatical "Tumours." The omission of cretinism as occurring with enlarged thyroids, and of old iritis, as presumptive evidence of syphilis, are but small blemishes on an excellent work.

Le Ventre. I. le Rein., par le Dr. M. Bourcart pp. 302. viii. (H. Kündig, Genève) F. 9.

We have here an exhaustive treatise on the pathology of movable kidney, with a few notes as to its treatment. The first part consists of elaborate instructions as to palpation of the abdomen, with a good description of its regional anatomy, and many rules as to the "standards of female beauty." The illustrations, which consist of photographs and diagrams, hardly conform to English tastes—even for a medical book. The author does not despise verbosity and the illustrations are frequently repeated, so that, though advertised as 134, they really number 97. Dr. Bourcart condemns nephrorrhaphy and considers every case should be treated with an abdominal bandage, for the application of which he gives instructions. The various suggested causes for this pathological condition are clearly discussed, and we are told that it is generally caused by alteration in the abdominal contents associated with a congenital malformation of the "bed" in which the kidney rests. There is no index.

Squint occuring in Children. Edgar A. Browne F.R.C.S.Ed., pp. 74. (Bailliére, Tindall & Cox) 2/6 nett.

This essay, admirably written in a pleasant discursive style, describes the ætiology, pathology and treatment of convergent concomitant squint as it occurs in children, who are generally suffering from hypermetropia. The author preaches with great vigour against the practice of treating these squints by tenotomy, which he considers never to be necessary: and insists on the importance of optical exercises and bimanual drawing as giving excellent results in his hands. A good index and details of several cases followed up into adult life are additions to a most useful book.

Adenoids. Wyatt Wingrave, M.D. Medical Monograph Series, ix. pp. 128. (Baillière, Tindall & Cox) 3/6 nett.

Since Meyer, in 1868, first introduced adenoids to the medical profession, many have been seen and diagnosed, until now no operation is more frequently performed than their removal. In the book before us a capital and clear account is given of the symptoms caused by these growths of the naso-pharynx, and we are particularly told that the *symptoms* constitute the most important point in the diagnosis. It is an excellent treatise, and will well repay perusal, especially by the general practitioner, to whom this disease was hardly known in his student days, as it clears away many erroneous impressions that exist on the subject. We notice that the author prefers to operate with the patients—even children—in a sitting posture, and lays great stress on the importance of respiratory exercises as an after-treatment. There is a good chapter on anæsthetics, which, he says, should always be administered for children; and a warning is given against chloroform, as between 1897 and 1902 "more than thirty recorded deaths from chloroform have taken place during adenoid operations only."

In Lighter Vein.

AFTER all, it is not really difficult to be funny. One knows quite a lot of men who do it—with apparently very little mental effort. Take cabbies and 'bus drivers, for instance, one often hears them say very smart amusing things, though I don't recollect any just now. Still, it is a matter of common experience that these men are constantly facetious. These reflections, I may as well explain, were suggested by a letter which I received from the Editor of the GAZETTE, asking me to contribute something to the column called "In Lighter Vein," which he gives me to understand is devoted entirely to humour. I didn't answer his letter at once (if he wanted a reply by return of post he should have said so), but I put it into my coat pocket and determined to think the matter over. Anything which is worth doing at all is worth doing well; that is to say, doing at one's leisure and not just scrawling off in a hurry. That is why this communication has been somewhat delayed—besides, I didn't happen to put on the coat again for a few weeks, so that the matter wasn't brought prominently before me. Well, it will easily be seen now why I consider the remarks with which I began, distinctly consoling. It *isn't* really difficult to be funny—a little sense of disproportion, one's natural store of good spirits, and a racy way of expressing oneself, and the thing is done. Of course one has to consider one's audience so to speak. What would be really funny in *Punch*, or one of the professedly comic papers, would look tame in a police court report or in a scientific journal. With a view of getting out of my present difficulty—I mean to say of ascertaining what would be thought funny in the GAZETTE—for as I said it isn't difficult to be funny in the abstract—I looked over several back numbers in order to make a few notes of the sort of humour which seemed most usual, and therefore I suppose the most satisfying on the whole. But the extreme diversity in both the subject-matter and the style of these compositions made any deductions impossible. Perhaps it is as well, as after all originality is the great point, and if one can't be original in one's humour, one had better give the whole thing up and take to collecting picture post-cards.

Talking of originality, I remember a very amusing and original remark which was made at a branch meeting of the B.M.A. last year. A case had been shown of some rather rare condition, it may have been hypertrophic stenosis of the pylorus or something of that sort, and when the discussion was over a man got up and amused us all very much by what he said. Perhaps, though after all, it wouldn't look so funny in print, as much depends on the way these things are said—the tone of voice and so on—besides I am not sure now that I exactly remember the point he made, so let that pass. It serves to illustrate what I have always said, that it isn't really a difficult thing to be funny.

Even Scotchmen can be funny. I well remember several jokes made by a Scotchman who was H.-S. at Guy's many years ago, but who is now an eminent surgeon. He was called Mac, which seems to be a common nickname for Scotchmen. His had been a varied career, in the course of which he had learnt to make jokes without looking in the least as if he had done so. In this way he managed occasionally to hit the Vice-President without being fixed. But this is a digression, and I must now come to the main point and be really funny myself. The story I am about to tell . . . .

[I said 500 words. You have had more than that.—ED. G H.G.].

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

A case of Thrombosis of the Pulmonary Artery following Labour.

The following case may be of interest to your readers, illustrating as it does a rare cause of death following labour. Mrs. B. G., æt. 31, multip., was attended by me for her second confinement on August 18th. The labour was perfectly normal and only lasted for four hours. The patient progressed perfectly well in every respect, lochia, temperature, and pulse normal. On Sunday, August 21st, at 3.25 a.m., the nurse, who was sleeping in the patient's room, was awakened by the baby crying: the baby had been sleeping on the mother's right arm; the nurse got up to feed the infant and then noticed that the patient was breathing heavily, and also that her face and lips were very blue: she immediately sent for me but the breathing slowly stopped and at 3.40 a.m. she died. The patient was perfectly well at 1.30 a.m., and had expressed her delight to the nurse at her satisfactory progress. The patient had always enjoyed good health and had never had any illnesses except those peculiar to childhood. Her first confinement was normal in every way. She had for some weeks before her death expressed dread of her approaching labour, as "she felt that something was wrong with the child owing to some fright she sustained when about four months pregnant."

She did not suffer from any varicose veins, during both pregnancies and was, as far as we could judge, a perfectly healthy woman. Necropsy was made twenty-four hours after death. Rigor mortis was well marked. Post-mortem staining was noticed on the back, neck, and buttocks.

On examination of the thorax, pleuræ were healthy, lungs were dark red in colour and partly non-vascular. The pulmonary artery was first carefully dissected from the aorta, and opened by a longitudinal incision, and this was carried through into many of its immediate branches in the lung tissue. It contained a clot of dark red blood, soft and friable, not discoloured in any way, and not adherent to the walls of the vessel. It apparently began just above the pulmonary valves and extended forward into the branches of the vessel. On section of the lungs clot could be seen in all the branches of the artery. The lungs themselves were healthy. Weight of right lung 18½ ozs., and left lung 22 ozs.

Heart.—The right auricle contained a quantity of liquid dark red blood: the auricular appendix contained a clot, dark red in colour, soft and friable to touch, and was not attached to the walls of the cavity. The tricuspid valve was normal and admitted three fingers. Pulmonary valves, normal, easily retained water.

The clot referred to above did not touch or pass through these valves, but apparently formed about an inch or an inch and a half above them. Right ventricle normal. Left auricle, healthy. Mitral orifice admitted two fingers. Cavity empty. Left ventricle healthy. Aortic valves healthy and competent. Coronary arteries healthy. Aorta showed one small patch of atheroma, otherwise healthy. Weight of heart, 10 ounces. Kidneys normal. Liver normal. Brain normal.

Pelvis.—Uterus occupied a position midway between the umbilicus and crest of pubes. The outer surface of the uterus was carefully examined and also the vessels running to it, but nothing abnormal was found.

On section, the organ appeared healthy, the placental site was of a deep purple colour, but no signs of any pus or odour present. Cavity empty. The right ovary contained a well marked corpus luteum of pregnancy. Iliac and femoral veins were carefully examined for any signs of thrombosis but none could be found.

I have regarded this case as one of primary thrombosis in the pulmonary artery. First, because of the absence of any thrombosis of the iliac and femoral veins or of any abnormality of any of the vessels supplying the uterus: and secondly because of the appalling suddenness of death in this case. The view of primary thrombosis is favoured by Playfair and other authorities.

Another unusual feature of this case was the early occurrence of death after the labour; as this rarely occurs before the end of the second week.

Apparently the patient would have been found dead had not the infant's cries aroused the nurse.

The nurse is experienced, reliable, and observant: she informs me that the patient appeared to be in no pain and only asked for water to drink, and there were no "death struggles" of any kind.

ERNEST F. CLOWES.

Wotton-under-Edge.

Change of Address.

Dr. J. Cecil Constable, from 2, Cranworth Gardens, Brixton, to 2, Brixton Road, S.W.

Mr. J. A. Donald, L.D S., from 8, Morrab Road, Penzance, to 40, Market Street, Plymouth.

Mr. Sidney H. Jones, L.D.S., from 117, Edith Road, West Kensington, W., to Hazelwood Lodge, London Road, Enfield.

Dr. T. Morgan, from Brecon Infirmary, to Garnant, R.S.O., Carmarthenshire.

Mr. C. Doswell Wallis, L.D.S., from Ronald Villa, Chaldon Road, Caterham, Surrey, to North Farm, Locko Road, Spondon, near Derby.

Dr. H. W Webber, from 4, Woodland Terrace, to 4, Queen Anne Terrace, Plymouth.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Recently several manuscripts have been received without the contributor's name being enclosed. These cannot be made use of until the Editor has received a postcard from the various correspondents.

Guy's Hospital Clubs' Union.

THE FORMATION OF THE CLUBS' UNION, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Blue Book, p. 17) to the Clubs' Union, any student of the hospital can obtain the privilege of membership of the constituent institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situated close to Honor Oak Park Station, on the London, Brighton and South Coast Railway, and to the Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Under such restrictions as are found necessary by the committees of the several clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground, with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

THE HOSPITAL "BLUE."—The "Blues" Committee, consisting of two representatives from each associated club, award "Blues" and "Half-Blues" to members of the following teams:—Rugby Football, Association Football, Cricket, Athletic, Lawn Tennis, and Water Polo, after considering the list of men suggested by the various Clubs' Committees through their delegates. Blues are awarded half-yearly, at the end of each session, so that the Rugby Football team be represented by fifteen Blues, the Association Football by eleven Blues, Cricket by eleven Blues. Blues and Half-Blues are awarded for Athletics, dependent on the recommendation of the Athletic Committee according to the performances at the Inter-Hospital Sports, while there are allotted to the Lawn Tennis three Blues and three Half-Blues, to the Water Polo seven Half-Blues.

CONSTITUENT INSTITUTIONS.

THE FOOTBALL CLUBS.—President: Frederick Taylor, Esq., M.D. Rugby—Captain: P. F. McEvedy. Hon. Sec.: E. L. Ward. Captain Second XV.: C. E. M. Jones. Captain Third XV.: T. R. Harvey, and a committee of five, one representing each year. Association—Captain: P. C. Litchfield. Hon. Sec.: A. F. Denning. Captain Second XI.: A. Crofts. Captain Third XI.: J. T. Smalley, and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over sixty years, the season 1904–5 being the 61st. Very little is known about its early history. Among the many brilliant players who at one time or another have appeared for Guy's may be mentioned the following International footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (captain 1877–8), A. S. Taylor, W. G. Mitchell, A. Allport, H. W. Dudgeon (England); H. M. Jordan (Wales); R. Evans (Scotland); F. O. Stoker (Ireland); and E. Morgan (Wales).

In 1874 the Inter-Hospital Challenge Cup was instituted, which Guy's was fortunate enough to secure for the first time. Since its institution, St. Thomas's has held the Cup ten times; Guy's eight times; St. George's and London three times; St. Bartholomew's twice, and Middlesex and St. Mary's once each.

In 1891, Guy's, Middlesex and St. Thomas's were left in, the ties not being played out.

Last year, after getting as far as the Final, we lost the Cup to London Hospital. We hope to have a good team this year, and if only men will evince the same keenness as in the past we ought to regain possession of the Cup. We have three fixture lists arranged this season, and we propose to hold trial games at the beginning of the season, the first being fixed for October 2nd.

For the benefit of freshmen in particular, we may state that lists will be put up in the smoking-room and elsewhere, on which intending players should place their names as early as possible.

The officers of the club will be at all times very glad to give any information in their power.

The Association Football Club began its career in 1882, and has been carried on with much success since that time. In 1886 the Inter-Hospital Challenge Cup came into existence, and was won by Guy's for the first four years after its institution; during these years the Hospital twice won the Surrey County Challenge Cup. In 1894 and 1897 we again held the Inter-Hospital Cup, making in all six times. Reviewing last season, it may be said to have been quite the most successful the club has ever had, losing only one match on the card, doing well in the Surrey Cup, and winding up a most satisfactory season by bringing back the Cup. Most of last year's team are available for this year, and a good season is anticipated. The second eleven had an eminently successful season and played regularly throughout. The final for the Junior Cup was postponed until so late in the season that most of the team had left for the vacation, which was unfortunate, as judging by the form shown in the earlier rounds our eleven would not have had much difficulty in retaining the Cup. The third eleven played frequently too. Early in October trial games at Honor Oak Park will be arranged, more especially for the benefit of freshmen, and it is hoped that no freshman interested in "soccer" will hesitate for any reason to avail himself of this opportunity of proving his worth on the field, for it is largely on the result of these games that his later inclusion in the teams depends. Notices of the trial games

will be duly posted in the Smoking Room of the College. In the next issue of the GAZETTE a complete list of the season's fixtures will be given.

THE CRICKET CLUB.—President: W. A. Brailey, Esq., M.D. Captain: H. D. Wyatt. Vice-Captain: F. Morres. Hon. Secretary: R. Willan. Captain 2nd XI.: G. N. Bartlett. Captain 3rd XI.: A. Vernon-Taylor, and a committee of five.

Guy's have the best cricket ground of any London hospital and generally turn out a good cricket team.

Since the institution of the Hospital Cup in 1882 we have won it on fourteen occasions. The Cup was won this season, Guy's beating Westminster, Charing Cross, Mary's in the semi-final, and London in the final.

We should like to add that our prospects for the immediate future are fairly hopeful, and that though the Cup-ties lend themselves better to records, we do not wish to give them undue prominence, as perhaps many of our ordinary time-honoured fixtures are the more enjoyable matches.

THE ATHLETIC CLUB.—President: R. Clement Lucas, Esq., B.S., F.R.C.S., Hon. Secretaries and Treasurers: P. C. Litchfield and A. W. Berry; and a committee of eleven. The annual meeting of the Athletic Club is held in June at the Clubs' Union Ground.

THE LAWN TENNIS CLUB.—President: W. Arbuthnot Lane, Esq., M.S., F.R.C.S. Captain: F. W. M. Palmer. Hon. Secretary and Treasurer: A. Zorab, and a committee of eight. The club has been in existence some twelve years. There are sixteen very good grass courts at Honor Oak, which are open for play from the end of April to the end of September. The club holds, at the beginning of the season, several trial games, which serve to bring before the notice of the committee all promising new players, while one or two matches are played weekly against various London clubs. The Inter-Hospital Challenge Cup was instituted in Jubilee year; it was held by St. George's until 1890; Guy's held it in 1891-1892; St. Thomas's, 1893-1896; St. Bartholomew's, 1897; London, 1898; St. Bartholomew's, 1899 and 1900. In 1901 it was won by St. Thomas's, by London in 1902, by St. George's in 1903, and by London in 1904. A cup was also presented in 1899 by the late Dr. Washbourn, for a competition for second teams, which has been won this year by St. Thomas's.

THE RIFLE ASSOCIATION.—President: L. A. Dunn, Esq. M.S., F.R.C.S. Vice-Presidents: G. Newton Pitt, Esq., M.D, A. P. Beddard, Esq., M.D., E. I. Spriggs, Esq., M.D., Captain: G. C. F. Robinson. Hon. Secretary and Treasurer: R. E. French, and a committee of five.

The Association arranges matches with the sister hospitals of London and with public school cadet corps, and also enters a team to compete for the United Hospital Challenge Cup at Bisley during the "week." Both civilians and volunteers are now allowed to compete in the United Hospitals Competitions and in the Bisley Cup; but there are numerous advantages attendant on a membership of a Volunteer Corps, and the honorary secretary of the Association will readily give any information required with regard to suitable corps.

The Annual Prize Meeting and the Newton Pitt Challenge Cup Competition are held in July, before the close of the session. Due notice of these and all other events will be posted on the notice board in the Colonnade.

It is earnestly requested that each and every man interested in shooting will communicate early with the Secretary, so that the Committee may have some idea of the number of men for whom they have to arrange next season's programme.

The Annual General Meeting will be held early in October (notice of exact date will be posted conspicuously) and it is hoped there will be a good attendance.

GUY'S HOSPITAL SWIMMING CLUB.—President: Sir Alfred Fripp, M.S. Vice-Presidents: J. H. Bryant, Esq., M.D., C. H. Fagge, Esq., M.S., J. Lewin Payne, Esq., L.D.S., M.R.C.S. Captain: R. B. Dawson. Hon. Sec. and Treasurer: T. B. Layton.

THE PUPILS' PHYSICAL SOCIETY.—Hon. President: Sir Samuel Wilks, Bart., M.D., LL.D., F.R.S. Hon. Secretaries: E. I. Spriggs, Esq, M.D., and R. P. Rowlands, Esq., M.S.

This flourishing society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital.

At the Pupils' Physical Society, which meets each fortnight on Saturday evenings, a paper on some subject, not necessarily of medical interest, may be read by any member, to be followed by a discussion.

"Clinical and Pathological Evenings" are devoted to the exhibition and discussion of interesting cases or specimens which may be shown by any member.

Members are reminded that in connection with the Society the following prizes are offered for competition:—The Treasurer's Prize of £5 is given annually, and the subject of the Essay for the ensuing session will be announced later. The Society offers a prize of £10 for the best paper read during the session; a prize of £5 to the member who distinguishes himself most in the discussions; and a prize of £5 to the member who exhibits the best specimens of scientific interest during the session (see Clubs' Union Blue Book, page 46).

THE DENTAL SOCIETY.—President: R. Wynne Rouw, Esq., M.R.C.S., L.R.C.P., L.D.S. Hon. Secretary and Treasurer: J. W. Mawer. Committee: F. A. Husbands, A. Alan Forty, H. Snell, and H. E. Marsh.

The Society was founded in the early part of 1894. Its tenth session commenced in October last, and was eminently successful in every way; good papers were read and much interest was taken in the meetings by the members, as shown by an average attendance of forty-

one, and an average of six casual communications per meeting.

Meetings are held every month during the winter session. They are held in the Dental Lecture-room on the second Friday in each month, at 4 p.m. Papers on subjects of dental interest are read, after which a discussion takes place; clinical cases are also shown at each meeting; and one evening during the session is specially set apart as a clinical evening.

THE DEBATING SOCIETY.—President: G. H. Savage, Esq., M.D., F.R.C.P. Vice-Presidents: J. Fawcett, Esq., M.D., A. W. Ormond, Esq., F.R.C.S., and E. I. Spriggs, Esq., M.D. Hon. Secretary: H. A. Watney, and a committee of five students.

The Debating Society is entering on its thirteenth year of existence, and its eleventh as a constituent of the Clubs' Union.

Five meetings are usually held in rotation with those of the Physical Society and the Smoking Concerts. Any subject except theology may be debated. Private business is allowed. A "Ladies' Night" is held at the end of the Session, at which members bring their friends, who are eligible to speak.

THE GUY'S HOSPITAL GAZETTE is published on alternate Saturdays, from the library of the hospital, where copies may be obtained by all members of the Clubs' Union and by immediate subscribers.

Established in 1872, the GAZETTE was the first journal of its kind ever published in this country. It ran an uninterrupted course until November, 1879, and was then suppressed by the hospital authorities rather from excess of zeal than for lack of material. The present "new series" was inaugurated in 1887, and since that time it has continued to flourish without a break. The original GAZETTE was a two-leaf publication, and only had a small circulation in the hospital itself. Its circulation now practically includes all Guy's men throughout the world, as well as the Nursing Staff, past and present.

The management of the GAZETTE is vested in a committee constituted as follows: Three members of the Hospital or School Staff, *appointed yearly* by a School Meeting: two students, appointed yearly by the Clubs' Union Council: the President of the Residents for the time being: an Editor appointed by the Committee; A Manager appointed by the Committee, and other students, not less than four in number and not more than six, co-opted by the Committee.

The columns of the GAZETTE are open to contributions and correspondence from all sources, the writer's name being requisite as a guarantee of good faith, if not for publication. All contributions must be deposited in the Editor's box in the colonnade, or addressed to the Editor by post not later than Wednesday in each week of issue.

THE REPORTS.—Edited by J. H. Bryant, M.D., and F. J. Steward, M.S.

The first volume of the Guy's Hospital Reports appeared in 1836. The Reports are published periodically, and contain contributions upon professional and scientific subjects from the Staff of the Hospital and Medical School.

THE STUDENTS' CLUB.—Committee till 1905 (March). President: P. H. Pye-Smith, M.D., F.R.S. Treasurer: W. Hale White, M.D. Hon. Secretary: A. W. Ormond, F.R.C.S. Hon. Assistant Secretary: E. I. Spriggs, M.D., and a committee of eight.

The above-named manage the affairs of the Club, a full account of which will be found in the Clubs' Union Blue Book, p. 53.

GYMNASIUM.

The Pavy Gymnasium, which was built and furnished by the liberality of Dr. Pavy, is open daily for practice, and during the winter session a boxing instructor attends one day a week, and also a gymnastic and fencing instructor. At the end of the session a competition for prizes is held, and a display of gymnastics and boxing and fencing is given on the "Ladies' Night."

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. H. H. Carter, J. N. Barrionuevo, M. J. Mottram, G. C. F. Robinson, H. M. M. Woodward, F. Alcock.

Obstetric Dressers.—Messrs. G. Hamilton, T. Norman, F. D. Crew, A. H. Miller (November-December).

Dressers in the Throat Department.—Messrs. H. C. C. Mann, A. R. Brailey, A. V. Maybury, S. M. Wells, E. C. Hughes, R. Felton.

Assistant Surgeons' Dressers.—Messrs. H. E. H. Tracy, J. L. Rankine, W. R. Greening, J. S. Farnfield (Mr. Lane); C. F. L. Leipoldt, W. H. Miller, E. Morgan, H. C. Malleson, J. S. Farnfield (Mr. Dunn); A. Alcock, T. B. Layton, H. A. Pallant, A. Zorab, J. E. Hodson (Sir Alfred Fripp); G. R. Phillips, L. J. Paterson-Clavier, H. W. B. Walling, E. H. Paterson (Mr. Steward).

Medical Ward Clerks.—Messrs. G. Cockcroft, P. D. F. Magowan, I. Valerio, R. Willan, R. Davies-Colley, F. A. Barker, C. W. Greene, J. G. Phillips, H. J. Clarke, G. W. Goodhart, J. A. Von Wiehe, S. K. Poole, J. T. Smalley, G. F. E. Allison, S. W. Daw, P. F. McEvedy, A. T. Rivers, E. Wragg, A. Davidson, M. M. Earle, C. E. M. Jones, G. F. Luhn, B. K. Nutman, H. H. Moyle, E. L. R. Norton, A. Shepperd.

Surgical Ward Clerks.—Messrs. H. P. Aubrey, R. J. Reynolds, T. E. A. Carr, E. W. Giesen, H. J. Henderson, C. A. L. Mayer, W. P. H. Munden, E. N. Plummer, S. McK. Saunders, G. F. Stebbing, St. J. A. M. Tolhurst, H. Joste Smith, J. N. Watson, B. Wallis, E. B. Hinde, C. H. Marshall, R. P. Lambe, C. B. Ticehurst.

Clerk in the Skin Department.—Mr. C. W. Greene.

Aural Surgeon's Dresser.—Mr. A. R. Brailey.

Post-mortem Clerks.—Messrs. F. B. Lowe, R. O. Williams, H. S. Knight, F. M. Longson, L. J. J. Orpen, Turner, F. T. H. Wood, A. B. O'Brien, L. G. Davies, T. I. R. Cook.

Assistant Surgeon's Clerk.—Mr. F. H. Fuller (Mr. Dunn).

The uses of Electricity and Light in Surgery.

TREASURER'S PRIZE ESSAY.

Paper read before the Physical Society, by J. SEPHTON COOPER, M.A., M.B., B.C. (Cantab.)

(Continued.)

The true light treatment must now be considered. It was in the year 1893 that Finsen made known his researches in phototherapy in small-pox. Red light was used, as it cuts out the actinic rays, that is the blue and ultraviolet, which have an injurious effect, suppuration in the vesicles being due to the effect of light. In this country no great belief is expressed in the red light treatment, though Finsen himself is firmly convinced of its efficacy. In 1895 he published a paper on light as a stimulant. In 1897 he first made known his celebrated work in the treatment of lupus by concentrated chemical rays. Several people had used concentrated sunlight before by means of lenses, but it was Finsen who really developed the subject. From a series of experiments he came to the conclusion that there are in light certain rays which have an effect on the skin differing from heat rays in that they produce an erythema only after an interval of several days, varying from one to three, whereas heat rays produce an erythema almost immediately. These rays he discovered to be the ultraviolet rays. They are contained in ordinary sunlight, and indeed Finsen attributes the naturally darker appearance of the uncovered parts of the skin and the ruddy complexions of busmen and others to the effects of light rather than to wind and rain, as popularly supposed. Sunlight does not possess, however, sufficient rays for the treatment of disease, and so artificial light is made use of. There are indeed establishments where sunbaths are given, but it is for the general invigorating effects produced thereby.

The two principal methods of producing the ultraviolet rays are :—

1. By an electric arc lamp ; and—
2. By an electric spark from a condenser.

Dawson Turner, from his own experiments, has come to the conclusion that the spark light is richer in these rays.

Numerous experiments have been carried out to find the transparency of substances to the rays. Finsen proved that a bloodless tissue was more transparent than one filled with blood ; for this purpose he applied the rays to the front of a man's ear, having placed some photographic paper behind it. He found that when the ear was full of blood there was no reaction in the paper in five minutes, whereas with the ear bloodless the paper was blackened in twenty seconds. Turner found glass, mica, paper, rubber and several other substances opaque to the rays ; he found that the most transparent were polished pure rock salt, then ice and polished quartz lens. We may note that though ultraviolet "light" may be found in the X-rays tube it cannot penetrate beyond the glass.

The object, then, in treatment is to concentrate the ultraviolet rays as well as the blue and violet, which have some actinic action on the part to be treated, and at the same time to cut out the heat rays. With the arc light, as employed by Finsen, there is a considerable amount of heat. He uses a lamp of 30,000 candle power with carbon electrodes, around this are arranged four telescopic tubes to concentrate the light, the lenses are made of quartz, and there are spaces for water to absorb the heat ; the skin is compressed and rendered anæmic by a pair of quartz lenses, between which is a stream of water. Other modifications have appeared ; of these the Lortet-Genoud lamp may be mentioned, as when it first came out it was said that the exposure would be considerably shortened. I believe, however, that at the London Hospital they find an hour's exposure best, the same as with the Finsen, although Dawson Turner, in his book, says that fifteen to twenty minutes' exposure gives as good results as one hour with the Finsen lamp. Another modification is the Barry lamp, which is fitted with iron electrodes, the spectrum of iron being richer in ultraviolet rays than carbon. The ultraviolet rays have been found to have a decidedly bactericidal action, and hence it was hoped that much good might be done in disease of the skin due to bacteria. This hope has been well justified in lupus and also in rodent ulcer, though no minor organism has yet been found in the latter.

I will now give some results reported by various authorities with these lamps, and then say something about the spark lamp. I have been fortunate enough to obtain one of Finsen's pamphlets, in which he states the results of his treatment up to October 1st, 1902.

The total number of cases under treatment was		804
I. Cured		412
A. Free from recurrence from 2 to 6 years	124	
B. " under 2 years	288	
II. Nearly cured		192
III. Still under treatment		117
A. Much improved	91	
B. Only slightly better or transitory ...	23	
IV. Treatment interrupted		83
A. Not satisfactory	16	
B. Died	31	
B. Suffering from other severe complaints	13	
C. From other extraneous circumstances	23	
		804

Thus there were only 16 really bad results, or in other words, 2 per cent. of failures.

Dr. Macleod gives his opinion that the Finsen light is best for lupus ; out of 70 cases 11 were apparently cured and 1 made worse. Harrison and Wills, of Bristol, using the Lortet-Genoud lamp (afterwards supplemented by the spark lamp) report 42 cases of lupus vulgaris ; they say that the cases which responded best were those which

had received no previous treatment. Of the 42 cases :—

26 were improved and continued to improve.
5 were relieved and were to be kept under observation.
4 were relieved in places, other parts remained to be treated.
1 was not improved.
1 was unsatisfactory through non-attendance.
2 had been treated too short a time for improvement.

In Dr. Sequeira's appendix to Finsen's work on "Phototherapy," he gives a resumé of Dr. Forchhammer's paper entitled, "The Finsen treatment and its present position in dermatology." He classifies the cases in two ways which are interesting to read, many of these cases are mentioned in Finsen's list quoted above. The first classification is based on the extent of the disease; anything above 50 square centimetres is extensive, and anything below slight.

	Slight cases.	Extensive cases
1. Chief treatment computed	83 %	52 %
2. Under treatment	11 „	52 „
3. Treatment abandoned ...	6 „	18 „

The second classification is based on the duration.

	Under 10 yrs.	More than 10 yrs.
1. Chief treatment computed	78 %	63 %
2. Under treatment	15 „	23 „
3. Treatment abandoned ...	7 „	14 „

There was a total of 640 with an unfavourable result in only 11. The rest left for various reasons. From this I should infer that slight cases are cured more easily than the more severe, and that there is not much difference as regards duration.

Extensive fibrous scars, intense brown pigmentation and much secondary infiltration were found to lead to prolonged treatment; lesions on mucous membranes and tuberculous disease of internal organs were found to favour recurrence, though not materially influencing the healing of skin lesions. Of other diseases, verrucose tuberculides of the skin were found to be favourably influenced by the light, but scrofulides of the subcutaneous tissue were unaffected. Of forty-four cases of lupus erythematosis, fourteen were cured and fifteen improved, and favourable results were obtained in all the early cases. Twenty-four cases of rodent ulcer and cancroid were treated with a favourable result in eleven.

Attached to the paper is a series of reports from other workers in the same field.

Dr. Sabourand considers it the "specific treatment" for tubercular lupus. Dr. Burgsdorf, Professor Lortet and Dr. Genoud, of Lyons, Professor Peterson and Wiljaminoff, of St. Petersburg, Mr. Malcolm Morris and Dr. Dore, of London, and Dr. Leredde, of Paris, all report on the excellent results which they have obtained. Mr. Malcolm Morris and Dr. Dore give the following summary of cases :—Of sixty-five cases of lupus vulgaris eleven were cured; there were no relapses in from six months to two years; in all these, with one exception, the area of disease was small. In most of the remaining cases a degree of improvement proportionate to the length of time under treatment has been noted. In cases in which ulceration was a marked feature, light was less effective. Of eleven cases of lupus erythematosus great improvement was seen in seven. Of twenty-seven cases of rodent ulcer in most of which, however, X-rays were used, favourable results were seen in twelve, but in most of them slight relapses have called for further treatment. In nine of the twenty-seven cases the diseased area was non-ulcerated and of small area. They give a word of caution as to the interpretation of these statistics. Mere figures do not convey an adequate expression of the beneficial result of treatment; in many cases every known method of treatment had been tried, and even when there was no visible improvement, the treatment checked the spread of the disease.

Dr. Sequeira, in the article referred to above, says that his own experience of nearly two hundred cases treated at the London Hospital amply confirm Dr. Forchhammer's statement. The only drawback is the length of time required and the expense, but with simpler apparatus, such as that of Lortet and Genoud, and more recently still that of Dr. Barry, there is great promise of reducing both these disadvantages.

From the above records I think it fair to conclude that in lupus vulgaris Finsen's light has now established itself as a means of cure. In rodent ulcer it is somewhat less successful but full of promise. In lupus erythematosus there is improvement but we do not know for how long.

Dr. Dawson Turner, of Edinburgh, claims that the condenser spark lamp is both simpler and more easy of regulation than any other sort. The lamp itself is pressed against the diseased area, the open end of it being fitted with a piece of rock salt or ice. Thus the rays have only one layer to go through, instead of two of quartz and one of water, as in the Lortet-Genoud machine, and moreover, the rock salt or ice is much more transparent to the ultraviolet rays than quartz and water. Again, the source of rays is much nearer the diseased area, and from his own experiments he (Turner) states that the spark lamp is much more productive of ultraviolet rays than the arc light. He says the time of exposure has been reduced from fifteen minutes with the Lortet-Genoud lamp to two and a half minutes with the spark lamp. Another advantage is that very little heat is produced, and so no cooling apparatus is required. Treatment is carried out for two and half to five minutes three times a week. He instances one case cured in a total of twenty seven and a half minutes given in this way. He comes to exactly the same conclusions as Finsen and others, the method being the same but carried out with a different apparatus.

Mr. Harold Gamlen uses the "spark" lamp, and says that in his experience it is the best for skin diseases. This applies not only to lupus vulgaris, but also to lupus erythematosus, rodent ulcer, and other troubles. The average sitting is ten minutes, and as a severe reaction must be produced, treatment must not be more frequent than once in three days. But dark skinned

people are more resistant than fair, an observation generally agreed to among writers on this subject. He has had under treatment forty cases, some of them of an exceedingly obstinate character, but so far he has not had a single failure. Points much in favour of this treatment, are that it is thorough, there is no staining of the tissue, scars left from former operations are eradicated and the skin is rendered supple. He concludes by saying that all the advantages of light are more marked in ultraviolet than in X-rays treatment. We have in this a form of treatment apparently quicker than the ordinary Finsen light, and with practically the same results.

Light, then, in lupus at any rate, seems to be as certain as most surgical operations: in all methods there must be some failures, and in comparison with such an operation as the so called radical cure for hernia I think it will come out more than favourably. Where light fails the X-rays often obtain a cure, in such cases as extensive and painful ulceration where the patient cannot bear pressure, and in inaccessible cavities, such as the nose and mouth, where the light cannot penetrate.

Dr. Norman Walker has published the following observations. A student suffering from lupus erythematosus of the nose noticed that it was always better after being exposed to the glare of the sun on the water while fishing. Dr. Walker treated numerous cases of lupus erythematosus which, by the way, seems to be particularly prevalent in Scotland, with the Finsen light and X-rays with varying results. Considering the student's case he tried the effect of light without pressure. The patient is one foot from the lens and is treated with twenty or thirty minute exposures on alternate days, after six or eight exposures improvement commenced and when once begun was rapid. Some cases were brilliantly successful and there was improvement in all, latterly he added 1 in 4,000 adrenalin which seemed to aid the cure. I have been unable to find any other accounts to corroborate the above facts.

In treating of the uses of X-rays in surgical disease, I shall not be able to say very much about the apparatus used; it has been so much discussed of late that it would be out of place in a paper of this sort, which does not pretend to any expert knowledge of electrical apparatus; nor do I intend to go into the relation of the rays to light or how the rays produce their effect. No clear exposition of this has been published.

First, I shall take X-rays in diagnosis, and then pass on to their therapeutic effects.

Much work has been done in the examination of fractures; indeed, it has become such a well-recognised method that there is danger of the former methods of diagnosis without X-rays falling somewhat into disuse or being carried out in a slipshod manner, especially in a hospital where the apparatus is at hand. I was much struck with the usefulness of this method the last time I was in the skiagraph department. A child had injured his thigh, and several competent surgeons had all diagnosed separation of the lower epiphysis of the femur, and had put the limb up by flexing the leg strongly on the thigh. The X-rays showed with remarkable clearness that there was no separation of the epiphysis, but a very long oblique fracture of the femur extending almost from the trochanter to the condyles, and the fixation aggravated rather than remedied the displacement. M. Destet, of Paris, calls attention to the large number of fractures unrecognised before the introduction of X-rays, especially those of the tarsus, particularly referring to the scaphoid, calcaneum and astragalus, and in easily recognised fractures, as those of the forearm, the rays demonstrated the displacement and direction of fracture more clearly. In conclusion, he says:—"In the light of radiographic observations, the whole history of fractures must be rewritten."

Reliance cannot be placed in the photograph alone; the limb must be examined in several positions with the screen, or there will be numerous cases in which, even with X-rays, fractures are missed. It is also possible to make out divided tendons with the rays, as tendon is more resistant than skin, though less so than bone. Foreign bodies, such as needles in the hands and feet, are easily made out, and can be localised by examining from various directions and by special methods. Coins can be seen in the œsophagus or abdomen, the thorax being fairly transparent to the rays, while the abdomen is only moderately so.

Apart from fractures and foreign bodies, certain diseases of bones may be diagnosed. There are various forms of growth, sarcoma and carcinoma, which cause erosions and irregular formation of new bone, which can easily be seen in a photograph. Tuberculous abscesses and the sclerosis of tubercle and syphilis can also be made out. Osteo-arthritis and exostosis will show as projections from the normal surface, and be easily recognised.

In the abdomen the most important diagnostic use is in the detection of calculi. Biliary calculi being mostly composed of cholesterin, are seldom, if ever, seen. On the subject of renal calculi, Mr. Shenton has published a valuable paper in the Guy's Hospital Reports. In the *Lancet* for 1903, Croker publishes three cases of X-ray burns produced during examination for calculus of the kidney, the examination lasting an hour.

Mr. Shenton says that there is no fear of a dermatitis unless the rays are used by an unskilled or careless hand. There has been no case of dermatitis during the whole time the rays have been used at Guy's. To be successful one must know the shadows of a normal abdomen, and one must use the screen in addition to the photographic plate. It is quite possible to miss a calculus by the latter method alone, as the stones may be obscured by the thicker shadow of bones.

Two hundred cases examined at Guy's resulted as follows:—

In twenty-eight calculi were found by the surgeon and by the rays.

In eight the surgeon found calculi, but the rays did not.

In eleven the rays did not show calculi, and at the operation the surgeon found none.

In two the rays found calculi, but the surgeon did not.

In the remaining hundred and fifty-three cases which were not operated on, the result must be put down as doubtful, but in many cases the negative evidence of the rays has been confirmed by subsequent history. On the whole, the positive evidence is almost perfectly reliable; the negative not absolutely. Mistakes are liable to occur in fat people, or where the stones are very small. The oxalate calculi show up best, the phosphatic calculi next best, and the uric acid variety are the least satisfactory. In the same way vesical calculi may be demonstrated.

Foreign bodies, such as bullets or bits of bone, may be seen within the skull and localised, and subsequently removed. I have read of a case of cerebral tumour being seen, the diagnosis being confirmed by subsequent operation. In foreign bodies in the eyes, the rays have proved of great use. Sweet has reported one hundred and two cases examined by X-rays to ascertain the presence of a foreign body. Sixty-five showed the presence of a foreign body, twenty-seven gave negative evidence. Of the sixty-five, one was glass, five were copper, six small shot, fifty-three were pieces of wire or steel. In every case the substance was at the spot indicated. Dr. Mayon gives sixteen cases examined. In thirteen the foreign body was found and localised by the rays; two contained no foreign body, and one was missed. The thirteen were verified by operation. The method of localisation was by two cross wires and two photographs, and comparing the relation of the body to the wires in two photographs. A stereoscope was also used.

In connection with localisation, mention may be made of the Mackenzie Davidson localiser, by means of which the rays are reproduced by means of silk threads. There is also the method of stereoscopic localisation, but more cannot be said about it. In removing bodies from the eye, the electro-magnet is often used. Mayon thinks the small magnet should be used, and condemns the large one of Haale as unscientific and only to be used when the small one fails. While on the subject of ophthalmic work, it may be mentioned that X-rays have shown good results in trachoma. Mayon says the granules rapidly disappear, but gives operation the preference, as the diseased tissue is completely removed thereby. Of nine cases of trachoma treated, five remained well; one cleared, but recurred in two months; two improved, and are still under treatment. Stevenson and Walser report four cases, two of which are cured and two are on the road to recovery. (They report one case cured by twenty-two applications of a mild high frequency discharge.)

Thus there is seen to be a very wide field for X-rays in diagnosis and in confirming doubtful diagnosis by other methods. It has proved itself of great service in the past, and is likely to be more so in the future. The scope of treatment by X-rays is now large, and it is steadily growing year by year, though one must be cautious in saying what can be cured and what cannot at present. In regard to fractures, use is made of the rays in seeing that they are progressing aright and are mending in a good position, and this can be done without removing the splints, thus better results being obtained nowadays than before X-rays were introduced. In the case of foreign bodies in the œsophagus, the X-rays may with advantage be used while "fishing" with forceps or "the coin catcher." The surgeon is enabled to see what he is doing and is not working in the dark. He may by this means avoid doing serious damage to the œsophagus.

The question of priority in the therapeutic uses of X-rays is a matter of contention; the earliest case I can find is one published by Desplignes in July, 1896, of a cancer of the stomach said to have been benefited by the rays. From this time onward there are reports in abundance of very many different diseases.

Observation of the effect of X-rays on the skin causing "burns," in the slighter stages of which the hair was seen to turn white and fall out, led to the idea that hypertrichosis might be treated by X-rays. Many cases have now been reported all over the world. Some of the most noteworthy are as follows. Schiff and Freund, in 1898, reported six cases of complete cure, and in 1900 they state as a result of this treatment that "it frees surfaces from growths of hair, no matter how thick, in a few weeks completely thus offering at the beginning of treatment a result only obtained by years of trouble with electrolysis." They let the reaction go as far as a slight temporary erythema which subsided in two or three days. Justasny reports forty cases in which he expects a cure, several have not recurred after a year. He says there must be repeated erythema. Startin has reported four with no recurrence in eighteen months, and forty "as near relieved as can be." Sjögren and Sederhabin give ten cases and conclude that repeated exposure will undoubtedly destroy the hair follicles. Pusey gives fourteen cases, of which nine were satisfactory, but the other five scarcely justify the treatment. He says the condition of the skin was improved when bad before treatment and was not damaged when good, though there was some almost imperceptible atrophy in some. In no case did the hair fall out without some erythema. In his book, which is among the most recently published, he sums up the work done and gives the result as only a qualified success. It is only to be recommended when there is a large area of skin to be cleared of hair. Treatment is for purely cosmetic effect, therefore one must take care not to cause atrophy of the skin, and as some erythema seems to be necessary it needs great care and experience. In discussing electrolysis, we noted the good results obtainable; on the whole when there are a few stout hairs to be removed use electrolysis, but if there are many and small ones X-rays is the only treatment appreciable.

For the treatment of lupus vulgaris X-rays have been used almost as much as light. The first application was perhaps suggested by the Finsen light treatment, but otherwise there seems to be no good reason why the rays were first tried. However the use originated, the treatment is now well established. Much work has been reported but when the effects are so well known there is no need to quote numerous statistics. Scholefied, Holland, Hall Edwards and Startin are among the principal workers in England. Pusey gives four cases with good results and mentions that the noticeable thing is the shrinking of lesions without ulceration and the wonderful cosmetic effect on the scars; the same may be said of old scars, which are rendered supple and white. Malcolm, Morris and Dore, in the "treatment of lupus and rodent ulcer by X-rays," say that when ulceration is a marked feature of lupus the Finsen light is not so good, but here the ulcers heal rapidly under the influence of X-rays; the drying effect is particularly striking. It is in the deep ulcer that the beneficial effect is proportionately more, perhaps because there is little lupus tissue left: rapid absorption of œdema has been noticed in several cases. In extensive disease the X-rays may be used as a preliminary to light, as the growth is checked thereby and can then be treated a piece at a time by Finsen's method. They think it doubtful if any lasting effects can be produced without some dermatitis. For mucous membranes X-rays give better results than light, and when inside the nostrils there can be no question that as the disease is inaccessible to light, the immediate results are encouraging; as the obstruction is relieved, the discharge ceases, and the ulcer quickly heals. But for permanent cure long treatment is necessary. Dr. Wild, of Manchester, gives twenty-nine cases of lupus treated with X-rays, and of these nine healed and nine were much improved; this gives sixty-two per cent. benefited, as against seventy-five per cent. by the Finsen light, but many of these were much more extensive than those treated with Finsen rays. Dr. Gamlin gives twelve cases taken at random from his books treated mainly with X-rays, in some assisted by the spark lamp; all the cases were cured in an average of twenty-nine sittings. He considers it necessary to cause a mild reaction at first which must be maintained. These results compare very favourably with those treated by light alone.

In lupus erythematosus a good many cures have been reported by various radiotherapists, but no one has, to my knowledge, published any series of cases. Pusey reports eighteen cases from different sources, of which only one was a failure, the others were all cured or vastly improved. Turner gives three cases, two of which did well; the other was only slightly improved. Not much reliance can be placed on these few cases, especially when one reflects on the number of successes which are reported, and the number of failures which never get into any journal.

From the above it appears that there is good ground for encouragement, but not nearly enough work has been done to come to a definite conclusion.

As in the case of lupus, the X-rays have established themselves as a definite cure for rodent ulcer. Many cases have been reported in England and more especially in America and on the Continent. In the report of American cases rodent ulcer and epithelioma are mixed up together under the name of epithelioma, or cancer of the skin. It is, however, better, as pointed out by Dr. Macintyre, to keep rodent ulcer apart from cancer in a class by itself and not to talk of a cure of carcinoma when a cure of rodent ulcer is meant. The layman may be misled and think a cure has at last been found for cancer, the disease he dreads more than any, and thereby hopes are raised without true foundation. What the public mean by cancer is the much more rapid disease involving the internal organs, and in that, as I shall show, there is little ground to think that X-rays have any effect.

The first case of rodent ulcer treated with X-rays was reported by Stenbeck, of Stockholm, in December, 1899. The following cases are obtained from American sources and therefore in the majority of cases rodent ulcer must be read for epithelioma. William has reported seven cases symptomatically cured and four which improved rapidly. Sjögren has reported four cases in which there was no recurrence in twelve, nine, three and six months respectively. Johnson and Merrill give sixteen cases, of which ten were cured; four were improved and showed every promise of a cure resulting; two showed no improvement. Pusey reports twenty-seven cases, mostly rodent ulcer, but one or two undoubtedly epithelioma, including one on the penis. He tabulates his results as follows, and this may stand for the general feeling in America. Twenty-one or 77·7 per cent. were, as far as the eye could judge, cured, and of these seven have been well eight months or more, some of them were slight and might easily have been cured by other means. Some were too extensive for surgery and some involved the eyelids and would have necessitated plastic operations. There were four cases of recurrence but only one of any extent; two showed some lesion still, and one which at first showed much resistance has now almost healed. In none of the cases was there any destruction of normal tissue. The scar in every case was soft and pliable and even in scars after previous operations there was much improvement in this respect.

Malcolm Morris speaks strongly in favour of X-rays for rodent ulcer and says they may be used in apparently hopeless cases. "They sometimes cure and seldom fail to relieve." Deep ulcers give better results as there is little diseased tissue except in the edge. There is one exception to this rule, and that is when bone or cartilage is involved. In the majority of ulcers some disease remains in the edge, and needs prolonged treatment. Some cases which prove refractory under the X-rays, yet yield to light, which will break down the hard edge. In conclusion he says that the small, non-ulcerated varieties of rodent ulcer do best with Finsen light, followed by X-rays, and the large ulcerated forms by X-rays followed by Finsen

light. Relapse has occurred in most of his cases after a shorter or longer time. Dr. Gamlin gives one case of rodent ulcer which was cured after a total of ninety minutes' exposure to X-rays. Dr. Wild reports seventeen cases of rodent ulcer discharged from treatment. In twelve the ulcer had completely healed, and in five there was no benefit or there was continued growth; four of these were complicating bone or cartilage.

Perhaps more work has been done on this subject by Dr. Sequeira of the London Hospital than by anyone else. He reports on over one hundred cases, and says that the satisfactory results that he first published are fully maintained. In his practice there was recurrence in nearly half the cases, but this was easily dealt with by further application of the rays. In the question of recurrence it is interesting to know whether it is due to some outlying cells escaping destruction, or to a "true" recurrence. Some sections examined by him point to the former being the case, but perhaps both occur. He agrees with Malcolm Morris that cases with a hard edge are more resistant, and that those with most destruction do best, cases involving cartilage do badly as it is impossible to get proper contraction. He says it is impossible to estimate the length of treatment as cases vary, some heal in ten or twelve exposures, others only in as many months. Two cases only were obstinate and resisted treatment; that they were rodent ulcer was confirmed microscopically. He has no hesitation in saying that the X-rays are best for rodent ulcer. No more need be said, as I think the above fully states the case, and most workers are in agreement with it. For true epithelioma X-ray treatment is very unsatisfactory; I have only collected a few cases, but they are not encouraging. Zeisler gives four cases which, I think, are epithelioma, on the lip, tongue, penis and hand respectively; there was recovery in all, at any rate for a time; some doubt seems to be implied. Wild gives three superficial epitheliomas which have benefited, but two recovered. In three dozen cases there was no improvement, and four cases of secondary epitheliomatous glands were treated without effect. Turner, of New York, gives three epitheliomas of the lips, two of which did well, and two of the penis, one only of which has improved. Codman relates one case of recurrence in the floor of the mouth and two of the penis treated without success. Rhinehart states that three cases of epithelioma exposed daily for five or six minutes, and fifteen minutes on the eleventh day recovered in a fortnight; this seems hardly credulous, perhaps he means rodent ulcer. Dr. Gamlin gives a case of epithelioma at first benefited, but later rapidly made worse. Seabury Allen gives two cases cured, and Pusey has a case of epithelioma with secondary glands, which he says is cured.

Looking over this short list it is clear that some cases may offer a doubtful cure, but the general impression is that epithelioma is not much influenced. The general opinion I have been able to form after conversation with several workers is that nothing like a genuine cure has been obtained. Discharge certainly is lessened, and a remarkable fact is that pain is very much relieved. These two facts alone make the treatment of some value, as it will at any rate help the patient to end his days in comparative peace of mind and comfort.

Although the fact that rodent ulcer and lupus can be cured by X-rays seems so well established, it is not so with malignant disease apart from epithelioma which has just been considered; much work has been done but not enough to settle the question. It is much to be hoped that with modification of apparatus and more experience better results will be obtained, but one must be very careful in expressing a too hopeful view, a brief summary of work that has been done is necessary though mere quotation of figures is tedious.

Gocht, in 1897, reported two cases, in one of which pain was relieved, the other died. Hopkins gives two cases of inoperable carcinoma of the breast, one was reduced from twice the normal size to normal in thirty exposures and all subjective symptoms ceased. In the other there was disappearance of pain and odour with some decrease in size. Fergusson relates a case of inoperable recurrent scirrhus in the breast and manubrium sterni, treated with X-rays for twenty minutes on as many days. Months after the patient returned in excellent spirits and health, the sternal growth had disappeared and the ulcerated surface was healed, the pain was less, but there was still some disease remaining. Soiland gives a case of ulcerated carcinoma of the breast. The ulcer healed and the patient's health improved, but there were some nodules left. Ayers, Andrew Clarke, Allen, Eijkmann and Martin relate fourteen cases, of which four were symptomatically cured, most of which, however, were recurrences. Johnson and Menill report four cases with no improvement. Pusey gives eighteen cases of recurrent carcinoma of the breast. Eight showed no result except relief of pain. One patient was relieved of local disease, but died of metastasis; five were symptomatically cured; four were much improved in health. One case of Paget's disease of the nipple is included. He also gives nine cases of primary carcinoma of the breast, one of which was symptomatically cured. In two who died the breast was examined microscopically. There was found to be much improvement, the breast only containing a small mass of fibrous tissue. In three others the disease was checked. He comes to the conclusion that even for the relief of pain and discharge and the improvement in general health, the treatment ought to be encouraged. But when operable, the surgeon should certainly be called in. In sixteen cases of deep-seated carcinoma there was no result except the relief of pain. In fourteen cases of abdominal tumour there was also no result except relief of pain. In eleven cases of uterine cancer there was relief of pain and cessation of foul discharge; nothing in the way of a cure was noticed.

Dr. Bryant reports a case of cancerous stricture of the rectum treated with the result that the patient was able to pass fæces without pain. Pusey gives two similar

cases. Dr. Gamlin gives a case of scirrhus apparently cured. Mr. Thomson relates a case of a large ulcerating surface of the left breast treated with X-rays with considerable improvement. Turner describes ten cases of primary carcinoma of the breast with one success, and five cases of recurrence with temporary improvement in all. Beck tells of four cases of recurrence after operation for carcinoma of the mammæ improved by X-rays. In a case recorded by Shattock a scirrhus which had not been operated upon was treated daily for four months with X-rays. After twenty days it was reduced in size. At the end of the four months it was excised and was half its original size, but shows no signs of degeneration and seemed to be spreading in all directions, a round celled infiltration being in advance of the spreading edge. Making an analysis of these cases I find that of one hundred and twenty cases, fourteen were symptomatically cured more or less, fourteen are described as unaffected, and the remainder were only benefited to the extent of relief of pain or cessation of discharge, and in some cases decrease in size of the tumour, which may have been simply diminution of œdema. Of the "caries," few were primary, the majority being cases of recurrence in the old scar. The result, 11 per cent of doubtful cases, is not very encouraging.

In sarcoma, slightly more favourable results have been obtained. Ricketts, Williams, Beck and Kirby have each reported a case improved by X-rays. Kirby's case treated very vigorously was a symptomatic cure. Coley gives ten cases of his own and four of others. In five the tumour had disappeared and in three there was a temporary check; in the others no result. In commenting on these he says that no one of them can be called a cure, but the disappearance of the tumour is cause for congratulation and encourages further efforts. He has never seen a case of sarcoma cured surgically, so it makes the above result more noteworthy. Pusey gives eleven cases with these results:—Four were cases of general sarcomatosis in which no more than palliative results could be expected; two were complete failures; three were symptomatic cures, and one was cured locally, but the disease recurred elsewhere. Turner has two cases of sarcoma in which the pain was relieved for a week. Codman relates a case of sarcoma of the sterno-clavicular region with a symptomatic cure. In all there are thirty-two cases, of which five are symptomatic cures, and most of the others were relieved temporarily; the percentage of cures—15 per cent.—is a little higher than for carcinoma, but one can go no further.

The general conclusions of the electro-therapeutic section of the British Medical Association last August sum up pretty well the present position of the treatment of malignant disease by electrical methods. There was general agreement on the following facts:—

1. That in rodent ulcer a satisfactory result may often be obtained.

2. That healing of an ulcerated surface in cancer has been observed in a certain proportion of cases.

3. Relief of pain is a fairly common experience.

4. That superficial nodules, undoubtedly cancer, will often disappear.

As regards epitheliomas, surgeons will not risk an operable case, which means that only inoperable cases have been submitted to the rays, rendering it an obviously unfair test. If the disease were only treated early enough, it is possible many more cures would be reported. From reported cases it is evident epithelioma can be profoundly influenced. In malignant disease the reported cures are all suspicious, and in most some flaws can be detected in the evidence. There have been many cases reported benefited, but very few, if any, real cures. It is quite possible that much failure is due to the unfavourable cases.

That cancer can be cured by X-rays has by no means been proved, and no surgeon is justified in allowing an operation—cancer, for example, of the mammæ—to be treated with X-rays only. They may be used as a preliminary before or a prophylactic against recurrence after operation. From reports I think it an undoubted fact that X-rays can be employed sometimes with much benefit in recurrence when this takes place. In inoperable cases, too, the use of the rays will often enable patients to end their days without the constant wearying pain and foul discharge which so often aggravate the agony of the last hours of the afflicted.

The subject of light has not been mentioned with regard to cancer as the light rays do not penetrate. As to whether light or X-rays treatment is best in lupus and rodent ulcer, opinions differ. Most authorities, however, seem to agree on the fact that "light," either as the Finsen light or as the condenser spark, is best for lupus vulgaris. In the absence of light, the X-rays form a very efficient substitute and in some conditions, as we have seen, light is no use at all. In rodent ulcer X-rays has the vote of the majority, but then again there are cases that X-rays apparently will not touch, and yet light cures them quickly.

Lupus erythematosus is a very difficult disease to deal with; sometimes light is best, sometimes X-rays, but for such an intractable and capricious disease it is something to have any sort of a cure; perhaps, on the whole, light is more beneficial, but if one fails then try the other.

The general features of radium I have already mentioned in my introductory remarks; whether its effects are produced by a bombardment, as it were, of the cells by the minute particles of matter which it throws off is still unproved, but this theory has been suggested, indeed, there are some who have suggested that X-rays produce their effects by a similar bombardment of small platinum particles from the kathode. I cannot go into this subject. The element has only quite recently been discovered, and therefore there is very little work reported as yet.

Mr. Sichel has reported a case of rodent ulcer of the cheek treated by this means, and as far as the eye can see a cure has been effected.

I have heard of a case of epithelioma which had been treated for two years with X-rays, but without success. Radium was tried as a last resort and the disease healed rapidly. More than this I cannot say, but from what has been already done there is great hope of more being accomplished in the future.

In conclusion, I may state that except in the treatment of lupus and rodent ulcer, the whole subject of Photo- and Radiotherapy is in a very early and unsettled stage. There are many other skin diseases which have been benefited by light or X-rays, and things more surgical, such as tubercular glands and joints, but there has been insufficient work published and I have had no time to spare to mention them. Much work has yet to be done, and it is to be hoped that our electrical department may be much enlarged in the near future. England is far behind America and the Continent in therapeutic researches; even in Spain they are better equipped than we are, a state of things which I think ought not to be allowed to continue.

The subject has been a difficult one to bring into one essay, but I think I have expressed the general opinion as it is at the present day.

I am indebted to the following:—

The Journal of Medical Electrology and Radiology.

The Lancet, 1903.

The British Medical Journal, 1903.

Lewis Jone's Medical Electricity.

Dawson Turner's Practical Medical Electricity,

Cheyne and Burghard's Surgery.

Cohen's Physical Therapeutics.

Pusey and Caldwell's Rœntgen Rays in Therapeutics and Diagnosis.

Phototherapy. Finsen. Translated by Sequeira Addyman. Practical X-ray work.

J. SEPHTON COOPER,
M.A., M.B, B.C (Cantab.)

Papers by Guy's Men.

A Lecture on the Treatment of Congenital Club-foot. By John Poland, F.R.C.S.—*The Clinical Journal*, 21st September.

The Red-light Treatment of Smallpox. By T. F. Ricketts, M.D., M.R.C.P. Lond, and J. B. Byles, M.B., B.C. Cantab, F.R.C.S. Eng.—*Lancet*, 10th September.

Tender Spots on the Spine in relation to pain in various parts of the body. By St. Clair B. Shadwell, M.D. St. And., L.R.C.P. Lond.—*Ibid*, 10th September.

A case of Bullet Wound of the Brain in which the bullet lodged about twelve centimetres from the point of entrance, and was extracted from a depth of 6·5 centimetres from the surface of the head. By William Sheen, M.S. Lond., F.R.C.S. Eng.—*Ibid*, 17th September.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

Births.

BAKER.—On September 13th, at Breiford, Hayes Road, Bromley, Kent, the wife of Arthur Ernest Baker, L.D.S., M.R.C.S., L.R.C.P. (44, Brook Street, W.), of a son.

HAMMOND.—On September 4th, at Carlyon, Shanklin, Isle of Wight, the wife of J. A. B. Hammond, M.B., of a daughter.

ROBERTSON.—On 11th July, 1904, at Naini Tal, India, the wife (née C. Rowland Jones, Sister Stephen) of Captain J. C. Robertson, I.M.S., of a daughter.

Marriage.

PARTRIDGE—JACKSON.—On September 1st, at St. Peter's, Preston, Sussex, by the Rev. Edward Riley, Aubrey H. Partridge, M.D., to Elinor May, daughter of Mr. Arthur Jackson.

Death.

BLASSON.—On September 2nd, at Harrogate, William Blasson, M.R.C.S., L.S.A., of Seymour Street, Portman Square, W., in his 69th year.

R. E.—ED.

GUY'S HOSPITAL GAZETTE.

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CONTENTS.

	PAGE.
Passim	413–315
Anæmic Vomiting. Clinical lecture by Dr. Beddard	416–420
Correspondence	420
Residents' "Going off" Dinner	420–421
A Letter from Rhodesia	421–422
Entrance Scholarships	422
Appointments	422
Papers by Guy's Men	422
An Interesting Case of Anthrax	423–425
Change of Address	425
Guy's Hospital Students' Club	426–429
Reviews	429
In Lighter Vein	429–430
Pass List	430
Sport	431–432

Passim.

THE Winter Session at Guy's, as at all the hospitals, is now in full swing. Members of the Staff and students are back in their places once more, and even the keenest holiday-makers have brought their vacation to a close and are hard at work again. As a change from the half-deserted appearance of six weeks ago there is a corresponding air of bustle and activity which is generally discernible at this time of the year. The daily papers report brief extracts of addresses delivered by influential personages to the new students, and the journals simply teem with wholesome advice calculated to encourage and admonish the junior men who are just making their first start in the profession. Some of us, over whose heads many winter sessions have come and gone, smile with a world-weary and cynical smile at the reams of good advice offered, for there is a sameness about it all every year which is just a little depressing. A certain witty and cynical French philosopher once remarked that some men like to give good advice because they are no longer able to set bad examples. Certainly the bestowal of good advice is a very favourite pastime with many people. Not that we deplore the fact, for it is seldom harmful. It may even sometimes be beneficial, for while it puts the donor on excellent terms with himself, it is in no way dangerous to the receiver, for he probably never by any chance takes any notice of it.

WRITING of introductory addresses and lectures, let us be thankful for one thing. A remarkable omission has been made by these monitors of youth, which is as pleasant as it is surprising. For the first time for many years we read of no one who, in his address, has dragged out Carlyle's aphorism about genius being the infinite capacity for taking pains. This is truly something for which we may be grateful, for it is a sentence which has been regularly drummed into our ears from our earliest youth upwards. We expected it on prize day at school just as we expected to hear the equally absurd dictum that Waterloo was won on the playing fields of Eton. We expected it and were never disappointed, but we liked to be spared it now. With all due respect to the memory of the Sage of Chelsea, we would like to remark that his definition of genius is both silly and untrue, for genius is surely the infinite capacity for doing things *without* taking pains. The man who is painstaking and persevering is acting both wisely and well, and he will reap the advantage both at the Examination Hall and in

after-practice, but a plodder is *not* necessarily a genius.

With regard to the cataloguing of the Wills library, to which we referred in our last issue, we have pleasure in publishing a letter this week from Dr. Shaw. Our readers will be glad, as he says, to learn that an efficient catalogue is being prepared with as much speed as is compatible with the other work in the library, and this catalogue will be arranged alphabetically both as to author and subject. The books on the shelves, too, are to be placed according to the subjects they treat of, and this classification will make it a very simple matter for any reader to at once lay his hand on any volume which he may require. We did not mean by our remarks in our last issue to put any blame on our esteemed librarian, Mr. Mills, for knowing well the arduous nature of his routine work, we thought it probably too heavy for him to do the necessary re-arranging and cataloguing. However, we most cordially agree with the Committee that the task could be in no better hands than his, and we may rest assured that the result will be most satisfactory.

The usual going-off dinner took place in the College dining-room last Friday evening. Everybody will be sorry to lose the retiring President, Mr. Brailey, and Vice-president, Mr. Wedd, but their places could not be better filled than they have been by the election of Mr. Pye-Smith as President and Mr. Box as Vice-president. The former has a hard time before him, as the President of the Residents in Christmas week is no sinecure; but we have no doubt that his term of office will be an unqualified success. The dinner was good, but the speeches were bad. Time was, before we had reached to the dignity of being a guest on these occasions, that we were accustomed to hear from a distant room in the College repeated volleys of applause, which we took to indicate the punctuation of brilliant addresses given by the various Residents. Applause was not wanting on Friday, but if it had not been for Mr. Hughes, who insisted on making several sparkling speeches, we should have gone to bed most disappointed. We must not forget to add that we saw a tiny gesticulating figure standing on a table with its mouth quickly opening and closing, but the words of filial advice given by a retiring H.-P. to his successors were drowned in the general hubbub. Several old favourites sang favourite old songs, but we should like to draw attention to the fact that Mr. Parker, since his appointment to R.M.O.B., no longer sings "More Work for the Undertaker."

Everyone is naturally anxious that we should make every effort this year to win back the Rugger Cup, and it is to be hoped that with the aid of some of our new men, we shall be able to produce a fairly strong team this season. Unfortunately we are losing the services of some of our best players, as Morgan, Harrison and Louisson are out of their year, and J. P. Jones is playing for Cardiff, so it is certain that we shall have to make an extra hard fight for it.

One improvement at Honor Oak we can now be sure about. The long talked of stand, having satisfied the demands of the County Council, will be in readiness for use towards the end of this month, and should be the means of a valuable addition to the gate money. We would remind men that Surrey has taken our ground for two occasions this year—for their match v. Middlesex Colts on October 29th, and again on November 26th, when they play Middlesex. On these occasions, naturally, a charge will be made for admission to the ground, and from this charge of course Guy's men will not be exempt.

The doctor, from time immemorial, has been a much abused person, and many and various are the sins of omission and commission which have been laid at his door. It has often been a grievance to some that medical science has not before this discovered an elixir vitæ, and the medical profession is blamed because, notwithstanding all its skill and research work, it has yet produced no infallible means for preventing human creatures from shuffling off this mortal coil. Now, there are others who come forward

and complain that it is the other way about, that modern sanitation and medicine are too apt to lengthen life, with an economic effect that is extremely objectionable, especially in the higher grades of society. A writer in the *Daily Telegraph* on the subject of marriage has been complaining that the age of directors, managers and others in foremost positions on railways, banking and commercial concerns is on the average greater than ever before, with the consequence that social promotion is checked and marriage prevented. "Even so simple and beneficial a thing as the prolongation of innumerable lives by artificial teeth," says the writer, "has prevented thousands of young men from entering the blissful state of matrimony." Against the medical profession this is a weighty indictment, and must give us pause. It is painful to think that so many years of work and investigation have been misapplied and that science has done so much harm. But if it is really true, as the writer suggests, that science has prevented him from marrying and propagating his species, then some good, at any rate, can be placed to its account.

A new use has been found for the stethoscope. Those of us who experience any difficulty in auscultation may congratulate ourselves that there are other purposes for which our instruments may be applied, and it has been left for an Edinburgh doctor to show us what some of these uses are. Coming home late one night he had reason to suspect that there were burglars in his dining-room. In order to verify his suspicions he put his stethoscope to the door and was thus enabled to hear their movements, whereupon he promptly called in the police and so captured the intruders. We are not informed as to what exactly were the adventitious sounds (can we call them bruits?) that he heard, but doubtless it was the noise caused by his nocturnal visitors in palpating and percussing the safe in order to discover what it contained. Would it be a kindly action or otherwise, we wonder, if we were to politely hint to the worthy doctor that had he applied his ear to the door he would probably have got just the same result with rather less trouble to himself.

Members of the Clubs' Union and particularly freshmen should note that the first meeting of the Debating Society this Session will be held on Saturday, October 22nd. The subject of the opening debate is not finally decided on, but it will be duly announced in the course of a day or two. The topics under discussion at these meetings are of varied interest, and it will be strange if one or more of the subjects do not appeal to everyone who is willing to take part. We have plenty of room for new speakers, and freshmen will be specially welcomed.

It is perhaps hardly necessary at this late hour to remind our readers once again that the first meeting of the Physical Society takes place to-night, when Professor Macalister will give his promised address. The fact that Sir Samuel Wilks is to be our chairman, will undoubtedly prove also a great "draw."

Papers by Guy's Men.

Two cases of Renal Calculus, in which the X-rays failed to indicate the presence of a stone. By R. Clement Lucas, B.S., F.R.C.S. Eng.—*Ibid.*

With Dr. Norman Meachen in the Skin Department of the Tottenham Hospital.—*The Clinical Journal*, 28th September.

A note on the Pathology of Lateral Curvature of the Spine. By G. C. Steele-Perkins, M.D.—*The Lanc* , 24th September.

The Treatment of Malarial Fever by Injections of Quinine. By Captain C. M. Fleury, R.A.M.C.—*Journal of the Royal Army Medical Corps* for October, 1904.

Epidemiology of Leprosy. By J. Ashburton Thompson, M.D.—*The Australasian Medical Gazette*, 20th August.

A Clinical Lecture on Injuries to the Spinal Column and Spinal Cord. By A. H. Tubby, M.S. Lond.—*The Clinical Journal*, 5th October.

Anaemic Vomiting.

CLINICAL LECTURE BY Dr BEDDARD.

May 18th, 1904.

Gentlemen, — Having only gone to-day into "Clinical," it is impossible for me to take one of the clinical cases, therefore I propose to take the subject of Anæmic Indigestion and Vomiting, because it is a very common condition. The importance of the subject consists in the fact that a large number of these cases are supposed to be cases of gastric ulcer.

I will briefly refer to four examples of it. There has recently been in the hospital, under Sir Cooper Perry, a woman who was admitted for pain after meals and vomiting. Her abdomen had been opened on two occasions at another hospital, but on neither occasion was anything the matter with her stomach found. At Guy's we resisted the temptation to open the abdomen a third time; she was treated as a case of anæmic vomiting, and apparently recovered fairly well. About a year ago I was invited to see a woman in "Clinical" who had been sent up in a great hurry on account of severe pain in the upper part of the abdomen and vomiting, and I believe she was supposed to have a serious and possibly perforated gastric ulcer.

On examination, a neat scar in her epigastric angle was noticed, and on enquiry it appeared that her abdomen had been opened at Guy's a year previously for the same symptoms but that nothing abnormal had been found. The next morning the symptoms had to a large extent passed off and they entirely disappeared in the course of a few days. At another hospital with which I am connected there was admitted a few weeks ago a woman for precisely the same symptoms; a sudden attack of severe pain in the upper part of her abdomen, with vomiting. She had had many of these attacks previously, but none so severe. She was admitted into a surgical ward on the day after the attack, her abdomen was opened and the stomach explored but nothing abnormal was found. As soon as she had recovered it was considered, I suppose, that the other likely cause for the repeated vomiting and abdominal pain was apppendicitis. They accordingly explored that region but found nothing. Then she was transferred to me as being probably medical; she was treated as if she were a case of anæmic vomiting and she got apparently well and went out. At the same hospital a nurse was admitted with the following history: She was twenty-five years of age and had always been healthy. She came to the hospital three months previously and must therefore at that time have been considered moderately strong, because all nurses are examined before acceptance. After a few weeks of nursing she began to suffer from the following symptoms: increasing pain after food, which was relieved by vomiting. She never had hæmatemesis and was rather constipated. The heart was three inches outside the left nipple line. She was warded and placed in bed and fed by the rectum, and in a few days the pain and vomiting had disappeared. Then she was placed on a bismuth mixture and given liquid food by the mouth, but the vomiting at once reappeared, and ceased when everything by mouth was discontinued. I saw her first at the end of a fortnight of this treatment, and she was exactly where she was when she came in, even the bismuth mixture caused acute pain and vomiting. Thinking it was anæmic vomiting I put her upon iron and arsenic and full diet, and in a few days her digestion was apparently normal. Then, owing to a mistake on the part of the resident, she was allowed to get out of bed and walk round the ward several times; at once her vomiting and pain came back. After a few weeks in bed, however, she went out apparently recovered.

What I want to discuss with you to-day is, What are the symptoms of anæmic vomiting, and what are they due to? And, in the second place, how do you diagnose the condition from other stomach conditions, especially from gastric ulcer? thirdly, how will you treat it?

Stomach trouble is divided into functional and organic, and one way in which you can tell roughly, one from the other, is the localization of the pain. People with functional stomach trouble have pain in the chest or the back, or the epigastric angle, but not over the stomach itself. On the other hand, many people with organic disease of the stomach have pain in precisely the same places as those with functional trouble, but they also may have pain actually over the stomach. You can say that if a person has stomach trouble with tenderness and pain over the actual organ, he has organic disease of the stomach. But to that statement there are three great exceptions, and they are so important that I am obliged to repeat them. In people with gastric crises the posterior nerve roots corresponding to the stomach are involved in the process. They have a very hyperæsthetic stomach, which occasionally empties itself by vomiting; and they naturally have

corresponding tenderness of the skin. These cases are not uncommon; I have seen two, in which surgeons were on the point of opening the stomach, whereas there was no disease present except gastric crises. The second exception is lead colic. The only time I called out an assistant physician when I was house-physician, was to see a barmaid, who I thought was a case of gastric ulcer, probably perforated. The first thing the assistant physician did, was to look at her gums, and there he found the blue line. I had not then seen the connection between barmaids and blue gums, but he had. Her symptoms were such that I think many people might have said it was a typical case of very acute gastric ulcer, or even of perforating ulcer. In lead colic you certainly may get extreme tenderness of skin over the stomach. The last exception are these cases of anæmic indigestion. They may have extreme tenderness over the stomach, but no organic disease of it. The first thing I want to explain is, How can a person with anæmia have this hyperæsthesia of the stomach and tenderness of the abdominal wall without having anything wrong with the stomach at all? What causes these symptoms? The thing which causes all of them is the heart; that is, it is stretching of the heart muscle which produces the hyperæsthesia of the stomach. When the heart is stretched you have skin tenderness corresponding to certain of Head's areas of the body. That is to say, these anæmic females who come complaining of pain under the left breast, are describing to you the position of Head's areas corresponding to the ventricles, and their stretching produces the pain. The stomach is supplied by some of the same segments of the spinal cord as is the heart, and when the heart is stretched there is often hyperæsthesia of the mucous membrane of the stomach. If the stomach mucous membrane is tender, or hyperæsthetic, you know that you are liable to get certain areas of the abdominal wall also tender. So that stretching of the heart is liable to cause pain in two places, namely, over certain skin and muscle areas of the thoracic and abdominal wall, and also pain and hyperæsthesia of a certain mucous membrane, namely, that of the stomach. Just as there is nothing the matter with the skin and muscles in such cases, so there is nothing the matter with the stomach when it is hyperæsthetic. When the skin is hyperæsthetic everything irritates it, so when the stomach is hyperæsthetic everything which is put into it irritates it, whatever it may be. That is, these patients may often find that drinking a glass of water may cause almost as much discomfort as eating a beef-steak. Therefore, these people find that they vomit and have pain whatever they put into the stomach. In gastric ulcer, however, it makes a great deal of difference whether you rub it with a liquid or with a solid.

It further follows that if a stomach empties itself by vomiting the pain will be to some extent relieved, because the stomach pain is partly hyperæsthesia, though it is also partly due to the rubbing of food along it. If their stomach pain is due to stretching of the heart, it follows that anything which stretches the heart will increase this stomach pain, consequently these people will tell you, or you can find it out by questioning them, that exertion causes them as much stomach pain as does food. If on exertion their stomach contains food it is more hyperæsthetic than usual and vomiting occurs.

Roughly stated, the symptoms of anæmic indigestion are these: pain after food, with vomiting, which relieves the pain, and anæmia. It is largely found in the female sex. Roughly, the symptoms are those also of gastric ulcer. How shall you diagnose between these cases of gastric ulcer and anæmic vomiting? That these cases are not always recognised, the cases I related to you at the early part of the lecture clearly prove. The importance of diagnosis is obvious, because, as we shall see, these two conditions require opposite treatment; the treatment for gastric ulcer is the worst for anæmic vomiting, and surgical interference with the latter is unjustifiable, so far as I know. Gastric ulcer is considered clinically to be overwhelmingly more frequent in women than in men, but that is not found to be true pathologically and surgically. I do not mean that those who have opened large numbers of abdomens do not find a preponderance of that condition among women, but nothing like the preponderance which clinical diagnosis seems to point to. And you know that duodenal ulcer, which is often associated with gastric ulcer, is three times as common in men as in women. All this is only a polite way of saying that a considerable proportion of the women who are said to be suffering from gastric ulcer are not. And if not, what are they suffering from? From my own limited experience I should say many of them are suffering from this "gastralgia," as it is often called, or anæmic vomiting.

What are the diagnostic points between them? At once one says hæmatemesis; if a person has hæmatemesis, then from the practical medicine

point of view she has gastric ulcer, provided there is a lesion of the stomach at all. I do not say there are not cases of people whose stomachs have no ulcer, but who have hæmatemesis. For all practical purposes, if a person has a lesion of the stomach at all you are bound to believe it is gastric ulcer if there is hæmatemesis. A large number of women in whom gastric ulcer is diagnosed have no history of hæmatemesis, so that hæmatemesis does not help you much in the majority of cases. One of the most important means of diagnosing between these cases is the history of the symptoms. The first and foremost symptom is pain. You have to find these things out by deliberate questioning, and you ask them, when does the pain come on. In gastric ulcer the pain comes on after food; it may come on at once because the food rubs the ulcer, but in some cases of gastric ulcer there is not pain directly after food, but only at the end of an hour or two. That is due to the acidity of the gastric juice, and the pain an hour or two after food shows that excessively acid gastric juice is tickling up the exposed surface in the stomach. In anæmic vomiting the pain is worse after food, but it may be severe apart from food, and especially on exertion, so that if a person has stomach pain apart from food and after exertion, it is impossible to maintain that that pain is due to gastric ulcer.

In ulcer, it makes a great deal of difference what food is eaten; these people will tell you of the difference in the pain caused by liquid and by beef-steak. Again, in gastric ulcer, exertion has no influence on the pain. Many cases of anæmic vomiting are treated as gastric ulcer, and they are dieted so that they have next door to nothing; a little milk and hot water, and bicarbonate of soda. You will find these patients vomit as much apart from food as they do after food, and often as much after liquid as solid food. So vomiting is in direct relation to pain, and as the pain in the one case is caused by food and in the other by either food or exertion, you can largely diagnose their condition by their answers to your questions about pain. You can also learn something by examining them. One of the most remarkable things about cases of ulcer is the extraordinary localization of their skin and muscle tenderness. The mucous membrane of the stomach is represented from above downwards by certain horizontal bands of skin; and as the lesion in gastric ulcer is circumscribed, it follows that the skin tenderness must be localised—the larger the ulcer the larger the area of skin tenderness. If the ulcer is near the cardiac end of the stomach, the skin tenderness must be at the top. If there is a circumscribed ulcer at the pyloric end, the skin tenderness must be nearer the umbilicus. But if the whole stomach mucous membrane is hyperæsthetic you do not expect to find only a small area of skin tender, but every part of the abdominal wall corresponding to the stomach. And that is what you find in anæmic vomiting—large areas of superficial tenderness, such as accompanies acute gastritis. Therefore, there is something to be learned in these cases from merely mapping out the areas of skin tenderness.

If the heart is at the bottom of the trouble in these cases of anæmic vomiting, it follows that examination of the heart must throw some light on the diagnosis. Thus, if you have a person with symptoms of gastric ulcer whose heart is perfectly normal in size, then it is extremely unlikely to be a case of anæmic vomiting. If you find enlargement of heart it may be either ulcer or anæmic vomiting. Most girls with gastric ulcer are anæmic, and many anæmic people have dilatation of the heart without having the acute stretching of the heart which causes the symptoms that we call anæmic indigestion or anæmic vomiting.

The way in which you can tell whether the heart is being stretched, is simplicity itself. It is not by the size, but by the presence or absence of skin tenderness corresponding to the heart. I have never seen a person whose heart there was reason to believe was being actively stretched who had not well-marked tenderness of skin or muscle corresponding to Head's areas for the heart. And though it does not follow that every such case must be one of anæmic vomiting, it is something towards the diagnosis.

As to the treatment, of course ulcer is a disease of the stomach primarily, and consequently the stomach is the organ to which you direct your efforts; and as in the case of ulcer elsewhere, the great point is to keep it from mechanical friction and from chemical digestion. Therefore, the general outline of treatment for acute ulcers of the stomach is to put the patient to bed, carry out rectal feeding for a week or more if necessary. Then she is put on liquid diet, which is subsequently gradually changed to one which is more solid.

With regard to the feeding of cases of gastric ulcer, an important point has been brought out by Pavloff's work. It is this. The pain in many cases of gastric ulcer is not directly after taking food but one or two hours after. Those who have examined the gastric juice of

these cases say that many of them have a condition of hyperchloridria, which, translated into plain English, means that their gastric juice has an excess of hydrochloric acid in it. You can, of course, endeavour to keep down the acidity by giving alkalies. The most important point with regard to Pavloff's work is with reference to the effect of different kinds of food in increasing or decreasing the acidity of the gastric juice. The carbohydrates, he showed, produced gastric juice which was lowest in acidity. And I am certain that if you look out you will find many people who have this pain coming on some time after food who are infinitely more comfortable on bread and butter and carbohydrates than they are on a purely liquid diet like milk and beef-tea. These latter have the power of stirring up the glands to turn out much more acid in the juice, and the consequence is there is more pain accompanying it. Milk produces less acid than does beef tea, but they both cause a good deal of acidity. Pavloff has also shown that oil put into the stomach does not cause the secretion of gastric juice. That is of great importance, because however carefully you feed these people by the rectum you give them quite an inadequate amount of nourishment. When there is a serious gastric ulcer in a wasted subject, and there is a chance of perforation occurring, you do not want the stomach to secrete a fairly acid gastric juice, or you may have another hæmatemesis, but if you can give these people by the mouth food which will lead to no gastric juice, it will be a great thing. The Germans have adopted Pavloff's discovery in medical treatment. In cases of gastric ulcer they feed per rectum, and in order to make up the requisite nourishment they give them olive oil by the mouth. You cannot persuade the Englishman to swallow crude olive oil, and the only way you can get it into his stomach is by means of a nasal tube. In twenty-four hours the Germans will introduce six ounces of olive oil, which cannot mechanically rub the ulcer, and which, if it produce any gastric secretion, will not cause it to be acid. That roughly is the treatment of gastric ulcer.

In anæmic vomiting you see there is a totally different condition of affairs. There is nothing the matter with the stomach; it is only that the mucous membrane of it is hyperæsthetic. Now if you once recognise that you have to do with some acute dilatation of the heart, the treatment becomes obvious. You must keep the patient absolutely at rest in bed. As to diet, if the stomach is hyperæsthetic in practically equal degree to everything, the patient can go on to full diet, which is much more likely than slops to remedy the anæmia. If you put these people straight on to arsenic it will, as a rule, stop their vomiting in twenty-four hours, though how it acts I have not the slightest idea. It is the only drug I know of which will stop vomiting in these people. You need to give them about ℥ij of the liquor arsenicalis three times a day together with a mild preparation of iron.

Another thing which arsenic will do good in is anæmic diarrhœa. You will not be long in practice before you will be consulted by a nervous lady who complains that after every meal she has to have her bowels opened. It is probably brought about by increased peristalsis —perhaps all down the alimentary canal— determined by food. You will often see anæmic vomiting and diarrhœa in the same patient.

But the treatment of your patient is only begun, because when you have got rid of the pain and got her on to full diet she is not cured. I mentioned that what is at the bottom of the trouble is the condition of the heart. The nurse I referred to lost her pain, but as soon as they got her out of bed, back it came with the vomiting, simply because her heart was dilated by the extra exertion. Therefore, you have to get the heart back to the normal size. Nearly all anæmic girls are found to have enlarged hearts, because they usually have to work hard, but few of them have bruits. I am sure the idea of many, that in people with a heart three inches outside the nipple line there will be a mitral systolic bruit, is not true. As a rule, these cases have no bruits of any kind. Therefore, if you judge entirely by listening you will overlook the fact that there is an abnormal heart. If you tell the person to go bed, she will say, For how long? because many people, so long as they can get about, will resent going to bed.

The question is, if you put such a patient to bed, at what rate will her heart come in. Roughly, you may say it is about half an inch a week; so if such a case has a heart two inches outside the nipple line, you can tell her she will have to stay in bed five weeks; the last half-inch (if you can get it in at all) takes longer than the others. But where people have been anæmic for years you will probably find that, whatever your treatment, the heart cannot be brought absolutely back. The question is, what does this residue of dilatation represent. It is the permanent damage which has been done to the cardiac muscle by the prolonged anæmia. You must therefore watch the hearts of these cases week by week, and if it stops going in you must give ℥ v. of strophanthus besides the iron

and arsenic. If, in spite of this treatment for a fortnight, the heart does not go in, you can tell the patient there will be no further improvement. When you have got the heart back to its smallest size, all you have to do is to keep it there, and if you do so it will be impossible for that person to get the symptoms of anæmic vomiting again.

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Tuesdays, October 11th and 18th, 1.15 p.m., Clinical Surgery, by Mr. Clement Lucas.

Saturdays, October 8th, 15th and 22nd, 1 p.m., Clinical Medicine, by Dr. Hale White.

Monday, October 10, Lecture by Dr. Horrocks, 1.15 p.m.

Monday, October 17th, Lecture by Mr. Higgens, 1.15 p.m.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Wills Library.

Dear Mr. Editor,—You have no doubt drawn attention to a much needed improvement in your recent notes about the catalogue of the Wills Library. Your readers will be glad to hear that the Library Committee are fully alive to the importance of having an efficient catalogue at an early date. They are having prepared a card catalogue arranged alphabetically, both as to author and subject. It is also proposed to arrange text-books and monographs upon the shelves according to subject, so that all intending readers can actually see the books contained in the library upon any subject which he desires to investigate. It is intended in disposing the books on the shelves to allow for expansion, so that the arrangement of volumes according to the subject may not be interfered with for many years. The present Librarian, Mr. Mills, has an intimate knowledge of the books upon our shelves, and also of the popularity of different classes of books amongst the readers, and his knowledge is invaluable in deciding upon the future arrangements of the volumes; accessibility of the more frequently used books is almost as important as a "scientific" classification. The Committee are entirely satisfied with the progress that Mr. Mills is making with the work of re-cataloguing, in view of the fact that his very onerous routine duties are not interrupted by this additional work. It is hoped that the process will be completed without any interference with the daily use of the books in the library by readers. This seems to the Committee to be of greater importance than that the catalogue should be completed with special speed. The old book catalogue which meets ordinary requirements fairly satisfactory, is, of course, still available. After our recent removal, and until the library has been thoroughly overhauled, it is likely that some small number of books may not be immediately accessible. With regard to the two books which you mention as missing, your readers will not, I am sure, regard this fact as indicating a complete disorganisation of the library when I state that one was marked in the catalogue as missing from the library when Mr. Mills first took charge fifteen years ago, and that the other, a thesis for an M.B. degree at Cambridge, is a thin pamphlet of about 30 pages, which has probably been asked for before, and which was completely obscured by its more ponderous neighbours. Please assure your readers that the arrangement and the catalogue of the books in the Wills Library shall shortly be worthy of their "beautiful home," and of Guy's.—I am, yours truly.

LAURISTON E. SHAW,
Hon. Librarian Wills Library.

United Hospitals Hare and Hounds.

Dear Sir,—I should be much obliged if you would allow me to utilise your columns to draw the attention of any freshmen at Guy's who may be keen on cross country running, to the above club.

By the kindness of the Blackheath Harriers we are again privileged to make use of their headquarters at the "Green Man," Blackheath Hill, and to join their packs, which are divided into fast, medium and slow. Details as to times, trains, etc., will be found on the notice board in the Colonnade. Matches are being arranged for this season against Oxford and Cambridge Universities, Blackheath Harriers, South London Harriers, Thames Hare and Hounds, and Wellington and Lancing Colleges.

The Inter-Hospital Cup will be competed for in February. Last season St. Bart.'s won the cup from Guy's after a tussle, by one point only, but as we ought to be fairly strong this year, it is hoped that all new runners—and on them much depends—will come forward and assist the old brigade to regain that cup.

Thanking you in anticipation for inserting this.—I am, etc.,

T. E. A. CARR, Hon. Sec.

Residents' "Going off" Dinner.

On Friday, September 30th, a most successful "going off" dinner was held under Mr. Brailey's chairmanship, at which the Residents, with their usual generosity, entertained a large number of guests. After an excellent dinner, speeches were made and healths were drank in the conventional manner. The chairman announced that Mr. Pye-Smith had been elected President, and Mr. Box Vice-president, for the next three months, and a very enjoyable evening concluded with "Auld Lang Syne."

A Letter from Rhodesia.

My last Gazette out contains a pitiful appeal from the Editor for copy, for writes he, "the dog days are upon us." Let this be my excuse for inflicting this. A fellow feeling makes us wondrous kind and it's over 90 in the shade here as I write, and though this will reach London with the November fogs, perhaps there may be still a vacant space.

The gold mine from which I write is the largest in Rhodesia, and great things are expected of it. The white population, men, women, and children, number over a hundred. The black population over two thousand. At present I see over sixty natives every morning. Always the same complaints, headache (generally malarial fever or dynamite smoke), pain in the side (mostly pneumonia), shake inside (dysentery). The majority would run a mile sooner than drink my medicine, but as I issue out every day the scoff tickets for the sick they make the best of it. Pneumonia is very prevalent; my cases in a year must run into hundreds. In the early part of the year I had a run of luck and never lost a case, consequently began to think I had discovered an infallible prescription. Then came the colder months and a more virulent type, and my daily rounds became disheartening indeed. Just about this time several cases were admitted to hospital, and I was extremely puzzled as to how to fill in the death certificates. Case after case was brought into hospital unconscious, no history; sometimes I was informed the boy had only been ill a few hours, yet on admission the condition was obviously critical, and as a rule symptoms were conspicuous by their absence. Some of these cases were due to meningitis, probably pneumococcal, others I am entirely at a loss to account for.

In the last fortnight I have had two amputations through the arm. The first case was that of a boy who was going down the main shaft by the ladder way. In some manner he got his arm through into the next compartment and it was caught by the descending skiff and very badly injured. In the second the native got his arm caught in the crusher which breaks up the rock from the mine. Of course both these cases happened on my busiest day, when I visit another mine and a police camp. I generally cycle to these places. It is a forty mile ride over bad roads and desperate hills in a scorching sun. The first case did give me time to have dinner first, but the second case I was informed of just as I rode up to my house, my thoughts pleasantly dwelling on clean raiment and something long in a tumbler. It was no joke to have to set to work at once and prepare everything for an operation. The secretary gave the anæsthetic in both these cases, and is simply invaluable to me, as he always gives the anæsthetic when I have to operate. Still, it's always rather anxious work. I noticed during the second operation that my patient was breathing very badly, and questioned my anæsthetist as to the state of the eye. He replied, "he could gather nothing from the expression of the eye." I thought it about time that I investigated matters, and found a widely dilated pupil. After leaving off the chloroform for five minutes the breathing improved In one case the compound manager assisted me. In his zeal he destroyed every chance of an aseptic operation. In the other case my volunteer assistant was looking decidly the worse for wear, and I had to operate entirely unaided. I had no one even to hold the mangled limb I was amputating. He handed me the safety pins most skilfully later. The first case died on the evening of the third day, the wound being perfectly clean, and the temperature normal. This boy had had the axillary artery and vein torn through at the accident, and a tourniquet had only been applied when he was brought to the surface. The hæmorrhage had been considerable and he nearly died on the table. I am afraid I did not pay sufficient attention to the pulse in this case. Its condition should have warned me to look out for squalls, but the normal temperature and clean wounds lulled me into a fool's paradise.

The second case is doing well, but there is a little suppuration; it would be a miracle if there was not, considering the surroundings and circumstances of the operation, which took place in a tiny surgery.

After the operation in each case the patient was left for the night in the surgery. The father of the first patient was left to watch him. I paid a visit and found the father deliberately curled up under his blanket fast asleep. The patient was tossing about and groaning, with the dressings all but off, and the wound exposed. The watcher over the second case I also discovered fast asleep.

These two operations have frequently recalled to my mind most vividly an incident at an operative surgery class at Guy's. The popular teacher was looking somewhat mournfully at the efforts of a decidedly unpromising student. "Well, Mr. Blank, I would rather my arm dropped off" It was just, but it was crushing; I don't think the remark fell on stony ground. How is it that so often the words of our pastors and masters come home to us in after life? I suppose everyone at times thinks somewhat sadly over the past with its lost opportunities, and of a future with its "might have beens."

My practice here is largely a brief practice. A "Brief" somewhat, I fancy, resembles the Indian "Chit." It is a message written on the first handy scrap of paper, generally in pencil and brought by a boy. Perhaps if I quote some I have received they may prove interesting.

"Please give bearer some 'Parragoric,' as much as you could purchase in England for 4d." After receiving this I felt that my education at Guy's had been shockingly neglected, I was quite at a loss to know how much "Parragoric" one could purchase for 4d.

"Kindly send me a nice up-to-date enema." I thought I had discovered a new "habit" at first.

"Mr. N—— has been very ill this last week. We both think it is a touch of sun stroke, his head is so awfully hot at the back and down the neck, he cannot hold his head up the pain makes him so dizzy. Can you let me have something for it. I have just given him a mustard foot bath." I forget what I sent.

"Kindly send me some phenacolin also some medicine for a bad cough and bleeding at the bowels."

From a girl aged 13 years living a few yards away; "Please will you mix me a bottle of lime water and olive oil. If you have no olive oil sweet oil will do." I was not informed of the condition this was required for.

Malarial fever is very prevalent here. As a rule patients diagnose the case and treat themselves. They have one fixed idea, that if they can sweat all will be well. The amount of suffering a man will endure to raise a sweat is marvellous. Phenacolin is their stand-by. If that fails they send for sweet nitre, and if I send it, for I often do, I have found arguing is a waste of time, the boy frequently returns to know the dose. I never tell them that though.

A case of scarlet fever recently developed here. It's extremely difficult to trace the source, as we are eighty miles from the nearest town. The patients are colonials, the worst type of colonial, they know everything and can treat it also. They possess a book entitled "Medicine by the Fireside," or some such title, and after carefully consulting this work they flatly contradicted my diagnosis and said it was measles. Events proved the correctness of my diagnosis. When I told them it was six weeks quarantine they thought it absurd. "Mrs. So-and-So has just been in and told us that her little girl had scarlet fever and the doctor allowed it out in a fortnight, at least. Her little girl had a stiff neck and pains in her arms and legs just like Emma's, so it must have been scarlet fever."

A small infant here, a few months old, had convulsions, which, I was certain were due to malarial fever, as all the other inmates had recently suffered. I gave quinine and the child after being desperately ill for two days pulled through. The mother informed me this same colonial lady had strongly advised her not to allow me to attend the baby. "What could doctors possibly know about babies?" She gave her two Dr. So-and-So's patent powders and advised her to use them instead of my medicine. The mother being sensible took the powders and told me all about it. I was more indignant because I had attended this very woman's baby through a bad attack of dysentry, and she had informed me—to my face anyhow—that I had saved its life.

I forgot to mention that "Medicine by the Fireside" informed the mother that "sulphur" was the thing to give in scarlet fever. She could not at all understand why I refused to give it.

Once I diagnosed "enteric" at a farm fifty miles from the nearest dwelling. I got laughed at for my pains. However, my patient came to see me three months later to tell me I had been correct. It appears that the patient had had a new partner out, and after being on the farm a week that partner had gone to Salisbury with a bad attack of "Malaria," so I was told at the farm. The occupants of the farm only learnt later that the bad attack of malaria had been diagnosed at the hospital as enteric, and that it had nearly proved fatal. There were o s ots in my case, but the most suspicious symptom to me was a severe headache suddenly ceasing on the tenth day. Great stress was laid on the irritability of the patient in the letter asking me to visit him. Naturally before going fifty miles to a patient one likes to have some idea of the case, and reading the letter carefully for some clue, this particular point made me think of enteric as one of the possible causes of the illness. Other symptoms led me to diagnose enteric. During the time I stayed at the farm, some twenty-four hours, the patient passed no stool. P. H. W.

Entrance Scholarships.

GUY'S HOSPITAL MEDICAL SCHOOL.

The following Entrance Scholarships and Certificates have been awarded:—

Senior Science Scholarship for University Students.—£50, Mr. P. P. Laidlaw, B.A., St. John's College, Cambridge.

Junior Science Scholarships.—£150, Mr. C. A. Wood, Guy's Hospital. £60, Mr. G. F. Haycraft, Guy's Hospital. Certificates: Mr. H. B. Kent, The Northern Polytechnic; Mr. A. B. Porteous, City of London School.

Entrance Scholarships in Arts.—£100, Mr. Geoffrey Dunderdale, Clifton College. £50, Mr. W. H. Catto, Royal College of Mauritius. Certificate: Mr. E. Duvivier, Royal College of Mauritius.

GUY'S HOSPITAL DENTAL SCHOOL.

Entrance Scholarship in Dental Mechanics.—£20, Mr. J. R. D. Ditch.

Second Year's Prize.—Mr. A. Alan Forty and Mr. J. W. Mawer, equal, £7 10s. each.

Appointments.

Civil.

Bowen, W. H., M.S. Lond., F.R.C.S. Eng., has been appointed Assistant Surgeon to the Royal Ear Hospital, Soho, W.

Eccles, Horace D., M.R.C.S. Eng., L.R.C.P., has been appointed Public Vaccinator, Kawakawa.

Military.

Lieutenant F. M. M. Ommanney, R.A.M.C., is appointed Medical Officer, 6th (Somaliland) Battalion, the King's African Rifles.

Papers by Guy's Men.

Fever in Children caused by the Indigestion of certain kinds of Carbohydrate Foods. By Henry Davy, M.D., F.R.C.P. Lond.—*The Lancet*, 24th September.

On certain defects in the Present Operation for Mammary Cancer. By W. Sampson Handley, M.S. Lond. (Illustrated). — *British Medical Journal*, 1st October.

An Interesting Case of Anthrax.

E. B., æt. 41, a sorter of raw foreign hides. Admitted on September 13th, 1904.

Previous history.—Unimportant.

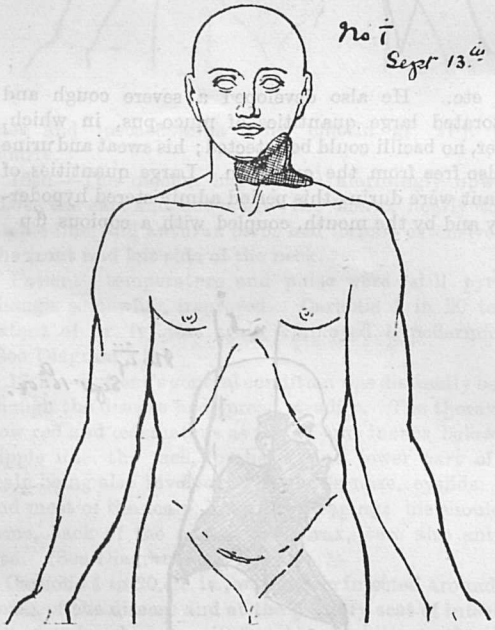
Present history.—On Saturday, September 10th, patient spent the day in the country, and got badly bitten on the face and arms by midges; these bites caused considerable irritation and were scratched by him.

11th.—He noticed one bite on the left side of his neck more painful and irritable than the rest; it was raised and slightly swollen.

12th.—The left side of his neck surrounding the bite became very tender and swollen. This swelling spread gradually over the side of the neck and across the middle line. He noticed a "fester" in its centre; there was, however, no general malaise in association with it.

13th.—Patient came up to the surgery on the advice of his employers and was admitted.

DIAGRAM 1.

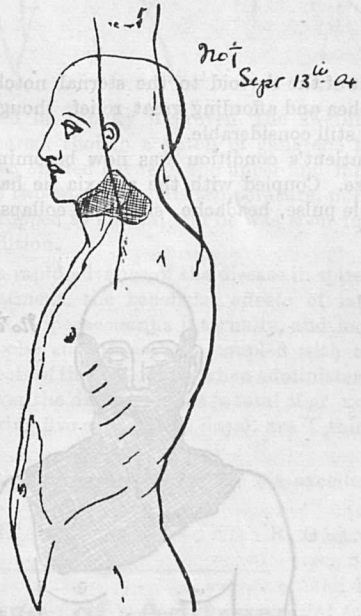


On admission.—The whole of the left side of the neck in its upper half and extending somewhat to the right of the middle line, was red, swollen, and painful. The submaxillary glands on the side affected being enlarged one and a-half inches below the level of the inferior maxilla, in a line with the angle of the mouth. There was a pustule about half-an-inch in diameter—raised and grey-yellow in colour—having no black centre. It was surrounded by a bright hyperæmic area which faded away into the surrounding œdema. (See Diagram 1.)

On microscopical examination of this pustule, anthrax bacilli in large numbers were discovered. Patient had no constitutional symptoms in association with the local disease, save a slight headache. His temperature was 99°. Immediately after admission the pustule was very widely excised, and the resulting cavity packed with sulphur. Ipecaccuanha gr. vi., and quininæ sulphas gr. iv., being given four-hourly, combined with a liberal diet and stimulants; a drastic purge was also administered.

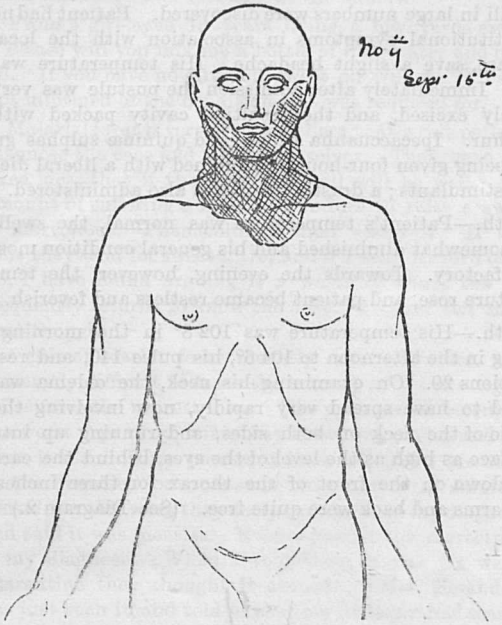
14th.—Patient's temperature was normal, the swelling somewhat diminished and his general condition most satisfactory. Towards the evening, however, the temperature rose, and patient became restless and feverish.

15th.—His temperature was 102·8° in the morning, rising in the afternoon to 104·6°, his pulse 140, and respirations 20. On examining his neck, the œdema was found to have spread very rapidly, now involving the whole of the neck on both sides, and running up into the face as high as the level of the eyes, behind the ears and down on the front of the thorax for three inches. The arms and back were quite free. (See Diagram 2.)



1 in 20 carbolic was immediately injected locally and along the advancing edge, which was raised and distinctly demarcated, 4 grs. of phenol being administered in all, and carbolic fomentations applied. The disease, however, increased so rapidly that the skin of the neck becoming tense the patient's respiration was greatly hampered, so much so that tracheotomy seemed imminent. In order to avoid this risk, which, if undertaken, would have involved probable infection of the lungs, an incision was made under chloroform from the upper

DIAGRAM 2.



limit of the thyroid to the sternal notch, exposing the trachea and affording great relief, though the dyspnœa was still considerable.

Patient's condition was now becoming progressively worse. Coupled with the pyrexia he had a rapid, very feeble pulse, headache, sickness, collapse, pains in the joints, etc. He also developed a severe cough and expectorated large quantities of muco-pus, in which, however, no bacilli could be detected; his sweat and urine were also free from the organism. Large quantities of stimulant were during this period administered hypodermically and by the mouth, coupled with a copious flu

DIAGRAM 3.

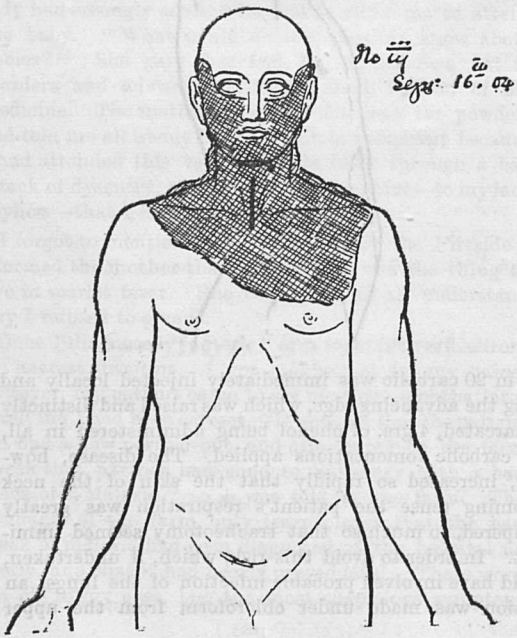
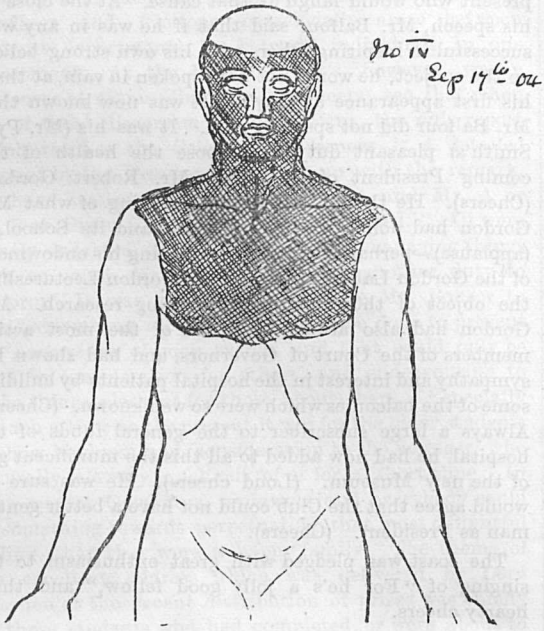
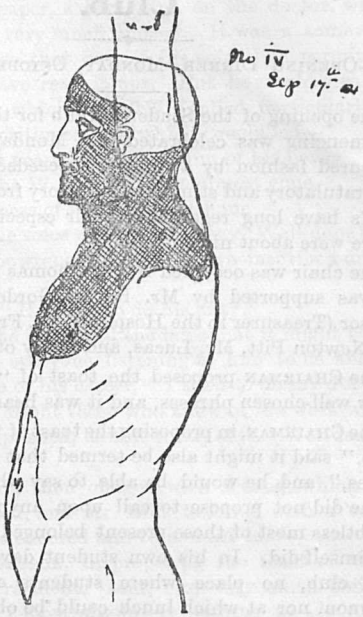


DIAGRAM 4.





diet and ipecaccuanha sine emetin gr. viij. three hourly.

16th.—The œdema had spread alarmingly upwards, above the ears and down into the thorax nearly to the nipple line, and anthrax blebs had formed extensively on the front and left side of the neck.

Patient's temperature and pulse were still pyrexial though somewhat improved. Carbolic 1 in 20 to the extent of gr. iv. was again employed hypodermically. (See Diagram 3.)

17th.—Patient's general condition was distinctly better, though the disease had spread steadily. The thorax was now red and œdematous as far as two inches below the nipple line, the face, forehead, and lower part of the scalp being also involved. Patient's nose, eyelids, legs, and most of the scalp, however, escaping; his shoulders, arms, back of the neck, and thorax, were also entirely free. (See Diagram 4.)

Carbolic 1 in 20, gr. iv., were again injected around the limits of the disease and at the primary seat of infection. His cough, though still troublesome, was relieved by drugs. No bacilli could be detected in the sputum.

18th.—The disease had ceased to advance, the limits of the œdema remaining the same as on the previous day. Patient's general condition was also greatly improved, and the cough and dyspnœa had subsided. There was still pyrexia. Carbolic gr. iii., was employed again as formerly.

19th.—The swelling had greatly decreased and his condition in every way improved. Carbolic gr. ij. were injected locally for the last time, patient having shewn no signs of phenol poisoning throughout.

From this period he rapidly improved, the swellings and blebs disappeared, though a patch of gangrene the size of half-a-crown ensued between the upper and inner extremities of the two wounds. His temperature, pulse, and respiration dropped to normal and he was soon in a convalescent condition.

In this case the rapid advance of the disease in spite of early radical treatment, the beneficial effects of large and frequent doses of ipecaccuanha internally, and local injections of carbolic subcutaneously, coupled with the non-poisonous effects of the latter drug when administered hypodermically over the diseased areas (a total of gr. xvii being injected during five consecutive days), are I think points of interest.

I am indebted to Mr. F. H. Fuller for his excellent report of the case.

Sept. 28th, 1904. R. G. A.

Change of Address.

Dr. Edward Cohen, from Fir Cottage, Whytecliffe Road, to Fernleigh, Brighton Road, Purley.

Dr. George Elkington, from 20, Egbaston Road, Birmingham, to Corphwysfa, Llwyngwril, R.S O., Merioneth.

Mr. C. S. Morris, L.D.S., M.R.C.S., L.R.C.P., 17, Railway Approach, London Bridge, S.E., and 27, New Cavendish Street, Cavendish Square, W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Guy's Hospital Students' Club.

Re-Opening Dinner, Monday, October 3rd, 1904.

The opening of the Students' Club for the session just commencing was celebrated last Monday in the time-honoured fashion by a dinner, succeeded by the usual congratulatory and stimulating oratory from those whom Guy's have long regarded as their especial benefactors. There were about ninety present.

The chair was occupied by Sir Thomas Stevenson, and he was supported by Mr. Robert Gordon, Mr. Cosmo Bonsor (Treasurer to the Hospital), Dr. Frederick Taylor, Dr. Newton Pitt, Mr. Lucas, and many others.

The Chairman proposed the toast of "The King" in a few well-chosen phrases, and it was heartily pledged.

The Chairman, in proposing the toast of "The Students' Club," said it might also be termed that of "Our Noble Selves," and he would be able to say what he pleased, for he did not propose to call upon anyone to respond. Doubtless most of those present belonged to the club, as he himself did. In his own student days there was no such club, no place where students could meet in common, nor at which lunch could be obtained without resorting to some dingy public-house in the Borough. He had rendered himself disagreeable to a former treasurer and many governors by persistently urging them to provide a place for common meeting, and to partake of a common meal. He had often lunched in that room, and though he belonged to a West-end club, he had never met with better society than he encountered in that room. The students' club possessed many advantages, and all who came to Guy's should join it; he was sure that for his subscription he would receive a very excellent return. He was told that the club was a very promising one, meaning that its future was well assured; but probably Mr. Ormond would say something later on the point. These annual gatherings were a very excellent feature, and were a great improvement on the former methods. He believed he had the honour —or dishonour—of being the last to give an address to commemorate the re-opening. There was so much moral talk, and so much wishy-washy talk, as well as excellent talk at those functions, that it was good that that feature had been discontinued at inaugural functions, and it had wisely been succeeded by such a meeting as the present. He asked all present to drink with enthusiasm to the students' club. (Cheers.)

Mr. Ticehurst next favoured the company with a pianoforte solo.

Mr. C. D. Pye-Smith, in proposing the toast of "The Health of Mr. Robert Gordon," remarked that when Mr. Balfour came to Guy's in 1898 to distribute the prizes, he said in the course of his address, that he had, all his life, been an ardent believer in a cause which was often laughed at—the cause of research. He (Mr. Pye-Smith) did not think there were many among those present who would laugh at that cause. At the close of his speech, Mr. Balfour said that if he was in any way successful in inspiring others with his own strong beliefs on the subject, he would not have spoken in vain, at that, his first appearance at Guy's. It was now known that Mr. Balfour did not speak in vain. It was his (Mr. Pye-Smith's) pleasant duty to propose the health of the coming President of the Club, Mr. Robert Gordon. (Cheers). He thought all knew something of what Mr. Gordon had done for Guy's Hospital and its School,—(applause)—perhaps the best known being his endowment of the Gordon Laboratories and the Gordon Lectureship, the object of those endowments being research. Mr. Gordon had also always been one of the most active members of the Court of Governors, and had shown his sympathy and interest in the hospital patients by building some of the balconies which were so well known. (Cheers). Always a large subscriber to the general funds of the hospital, he had now added to all this the munificent gift of the new Museum. (Loud cheers). He was sure all would agree that the Club could not have a better gentleman as President. (Cheers).

The toast was pledged with great enthusiasm to the singing of "For he's a jolly good fellow," and three hearty cheers.

Mr. Robert Gordon, in replying, said those present seemed inclined to repeat what was done on the occasion of the last dinner, when the reception accorded him drove out of his head nearly everything he had intended saying. He had felt much gratified by the receipt of the invitation to be a guest, but there was, perhaps, a little refinement of cruelty in sending that invitation three months ahead of the date for which the dinner was fixed. In preparing for great occasions like the present, one was supposed to be thinking of nothing else during the time which elapsed between the receipt of the invitation and the actual function. Thus he had had ample time in which to prepare one of the longest speeches ever delivered. But if any imagined he had prepared such a speech they were mistaken, and even if he had, he would not have been in a position that evening to deliver it, for he had been for some days under the hands of the doctor, who had only reluctantly given his consent for him (Mr. Gordon) to be present, and then with the strict proviso that he should be very careful what he ate, and not speak more than he could possibly help. It was therefore encumbent upon him to omit much of that which he had intended saying.

In the recently published Gazette there appeared a very admirable letter of advice to young students joining the hospital (Hear, hear). One paragraph impressed itself particularly upon him. The main point in our Guy's club is, we are all a happy family. It was a good thing to be able to say that, and as far as his own personal experience went, it was true; there was an extraordinary amount of *esprit de corps* pervading the whole establishment; from the highest to the lowest, all seemed impressed with the greatness of Guy's. In this, as, no doubt,

in many other hospitals and institutions, little misunderstandings and frictions occasionally arose between different departments, or between individuals in one department. At the head of Guy's, however, was a Treasurer of extraordinary tact—(cheers)—so that when one of those disagreements does occur, the only report which reaches the Court of Governors is a detailed account by the Treasurer, winding up with the remark, "I have settled all that satisfactorily, and Mr. A or Dr. B or Sister C is now perfectly satisfied." All were greatly indebted to the Treasurer for managing things with so much tact. But there was another duty to perform. It was not enough to leave Mr. Bonsor to settle everything, all possible should be done to prevent the occurrence of such events, and that could only be done by consideration for others, and endeavouring to make things pleasant for those about them. Especially at such a time as the present it was for the older students to show kindness and consideration to the younger, who naturally felt very much out of it for a short time. In that respect Governors, professors and everybody could do something towards perpetuating that most delightful feeling, that they were a happy family. The theme of the excellent address which was delivered by Lord Goschen at the recent distribution of prizes was chiefly for those students who had completed, or were about to complete, their college career, and were about to enter upon their career in the world. But it contained so much solid sense, so much admirable advice in all directions, that it might be studied with great advantage by the new comers. (Hear, hear.) Recently there appeared in one of the medical journals an article which had evidently attracted a good deal of attention, because it had been commented upon by many of the papers. He could not say it presented the medical profession in a very encouraging light. It clearly pointed out that the profession was one which could not be entered upon without very considerable expenditure, that there must be years of patient waiting, that there was great difficulty in finding an opening, and that the remuneration and fees, even if they were always paid—which he was sorry to say they were not—gave a pecuniary result which was seldom brilliant. But—and in all statements of that kind there was a "but"—the last paragraph said "It is the chief glory of the medical profession, however, that its standard of success is not the amount of money earned, but the amount of good done to our fellow man, and the quantity of new truths added to the sum of knowledge." (Applause). That, he hoped, was the motive which influenced a great many in entering upon the noble profession; he would be sorry if it was due simply to the money-making point of view; because, without doubt, the physician had it in his power to do an immense amount of good, quite outside his professional skill. From the peculiarity of his position, and the relations into which he was thrown with people and with those who were in grave distress of mind and body, the physician had it in his power to accomplish a great deal of good. He (Mr. Gordon) would be glad to think that all who came there to enter upon the profession were actuated by some such motive as that. (Applause). Quite recently he came across, in an American newspaper, a paragraph on the doctor, which impressed him very much indeed. It was a somewhat lengthy article, so that even if his voice had permitted, he would not have read it out. But he would give the last two verses, which probably applied particularly to the country practitioner, and which concluded—

"When the years have shorn him of his power
And from the West the light is almost gone,
In the stillness of life's twilight hour
He hears the voice of conscience say 'Well done!'"

The late Lord Lawrence desired to have inscribed on his tomb the words

"He tried to do his duty."

In conclusion, he expressed the hope that it might be the good fortune of everyone listening to him to be able to say, at the close of his career, "I tried to do my duty; I did my best." Might those who knew of the work which had been accomplished, be able to say of it, "Well done!" (Cheers).

Mr. Alan Forty then obliged with a song, which was much appreciated, and Mr. Ellis followed with a comic song, which was encored and responded to.

Mr. Cosmo Bonsor, in proposing the toast of "The Health of the President," said, I am very much obliged, gentlemen, but I have absolutely nothing to say about myself. But I have something to say because I am going to propose the health of the President of the evening. (Applause). Mr. Gordon made a most eloquent speech in answer to Mr. Pye-Smith's delightful speech, and talked about our being a happy family. It is perfectly true, and I will ask you why we are a happy family. Simply and solely because old Guy's men always continue to take the greatest possible interest in Guy's Hospital. It is a pleasure when we are presided over by an old Guy's man—I beg his pardon, for he does not look very old, but I believe it is forty-five years, or getting on for half-a-century, since Sir Thomas Stevenson first walked across the courtyard. Since then a good many things have been changed. Sir Thomas Stevenson has been changed. His Majesty, after a very long period, was good enough to consider the enormous services he had rendered to science and the State, by conferring a knighthood upon him. (Applause). I am confident that, while a knighthood was acceptable to Sir Thomas Stevenson, it was infinitely more acceptable to all his friends and Guy's Hospital. (Cheers). He is good enough, in proposing the toast of the Students' Club, to say that it is prosperous. I anticipated that Mr. Ormond, the Secretary, would have immediately got up and informed us it was in debt. Whenever I am told that Guy's Hospital is prosperous, it is my duty to get up and say Guy's Hospital is heavily in debt. It is quite respectable to be in debt; I believe the Students' Club is in debt, as well as the Hospital. Still, I agree with Sir Thomas Stevenson that it is extremely prosperous. He might have alluded to those cups there, and have suggested that at the next entertainment the President should fill them all

(Laughter). That would have been a very popular speech on the part of Sir Thomas Stevenson. I believe he forgot it. But, gentlemen, after all, we are extremely grateful to Sir Thomas for presiding over us, and very grateful indeed to all the gentlemen who take such an interest in the Students' Club at Guy's. A lot of them have sent telegrams—Mr. Golding-Bird, Mr. Symonds and others—but we would rather they had been here. Still, we are very grateful, and I am sure, that so long as the old men take an interest in the Students' Club, so long that Students' Club will prosper.

Only one word more: Mr. Gordon said we were a happy family; and why are we? Simply because we understand each other; we are all working for one common good; we are all practically working for the good of the patients in the hospital, and to elevate the fame of Guy's Hospital throughout the world. Only a fortnight ago I came back from my holiday, and I was informed that two gentlemen had been over Guy's Hospital that afternoon. One was an American doctor—perhaps someone here shewed him over—who said he had been through the hospitals of the United States and the hospitals in London, and that Guy's Hospital was a long way ahead of all (Cheers). That pleased me very much. The other gentleman who came over on the same afternoon, was an old Guy's man, who had not been in the hospital for ten years. He said "How the place has changed; I could not have believed that so much could have been done in ten years time," Those two shew the key-note of the policy of Guy's, We wish to advance, to advance in science, to advance in our treatment of patients, to advance in doing good. So long as we do this, I am sure we shall prosper. And now I ask you to drink to the health of one who has taken extreme interest in Guy's Hospital ever since he was a student, a gentleman who has done honour to Guy's, and who to-night we shall honour by drinking his health as our President (Cheers).

The toast was pledged with much enthusiasm, and with musical honours.

Sir Thomas Stevenson, in acknowledging the toast, said: Mr. Cosmo Bonsor, Mr. Gordon, and gentlemen all, I rise to thank you with all my heart for the very enthusiastic manner in which you have drunk the health of one who, though perhaps not the oldest in years, is the oldest member of Guy's present. I was under the impression that our Treasurer was an excellent solid Englishman, but I am authentically told that he has paid a visit to Ireland, and I suppose that he has been kissing the Blarney stone (laughter), so I ask you to discount very much of what he has said this evening. I am very proud to be a member of Guy's Hospital, and to be a member of the Students' Club. Our Treasurer is right in saying that it is forty-five years since I first saw this hospital, when I entered Guy's not knowing one single person in London. I have been perpetually a student, and to-day I commence my forty-sixth session (cheers), and I hope I shall be a student till my life closes. (Applause). Guy's has seen many changes during those forty-five years. The position of the student is very much altered. I ask those students, if there are any, as I suppose there are, who are now entering this Hospital, to consider Guy's their home, as it has always been mine. It is a place in which they will find every inducement to study, and by following the path of duty they will find all their happiness. Guy's has been a very happy family. Looking back on my forty-five years, I cannot say that I have ever had one enemy within the walls of Guy's (cheers), and that is due, greatly, to the strong *esprit de corps* which exists among teachers and students. The position of the Guy's student, as I have said, is very much altered. In my day we had one house-surgeon, who generally also did the duty of house-physician. I had that very arduous task to perform, and I will ask any one of the house-surgeons or house-physicians of the present day to think what would be their lot if they had all those duties to perform. But we did not know then what you know now; we had no thermometers, though we certainly had stethoscopes; and in my early days the physician used to tell us how the first stethoscope was introduced into Guy's Hospital by one of the physicians of the day putting it into his coat, instead of a flower, as a button-hole, shewing his appreciation of what we now consider as that very valuable instrument. Guy's has stood, I believe, pre-eminent among all the hospitals of the metropolis, and, I may say, of the world. I can speak of it not only as a student and as a teacher, but I myself have been indebted, on three occasions, to residence in this hospital for recovery from what I believed to be serious illness. Having been an ordinary patient in one's own hospital, I can speak of the immense value and the immense kindness which one receives in an institution like this. It has gone on, and will go on so long as we have such men as our treasurer, so long as we have such estimable governors and valuable governors as Mr. Robert Gordon Applause). We are only at the commencement of a long list of benefactors to this Hospital. Gentlemen, I thank you most heartily for the manner in which you have received this toast, and the greatest enthusiasm which you have displayed on this occasion for Guy's Hospital. (Loud cheering.)

Mr. Higgens, in proposing the toast of "The Health of the Club Secretary," Mr. Ormond, said he remembered Mr. Ormond as a student, he had known him some years as Registrar, and he could only tell those present that a nicer fellow, and a better and more able man to work with he had never had to deal with. (Applause). He submitted the toast with the usual honours.

The toast was very cordially pledged.

Mr Ormond, in reply, expressed his warm thanks for the honour which had been rendered to him by the cordial reception of the toast, most of all because it was quite unusual. When his predecessor, Dr. Fawcett, asked him to take the duties of Secretary of the Students' Club, he carefully searched for any precedent there might be for a Secretary having to speak at functions, but he failed to find any. Therefore he thought it unfair that he should be asked to speak on the present occasion.

Still, he thanked Mr. Higgens very much for what he had said. If the order had been reversed he would say that if he had been found easy to work with, the fact reflected credibly upon Mr. Higgens himself, who had been his senior and his friend. That summed up all that he would say of a man whom he (Mr. Ormond) knew little of at first, but whom he had befriended right through. He owed a great deal to Mr. Higgens, both professionally and in other directions, and, therefore, he felt it an extreme honour that that gentleman had said such kind things of him. (Applause).

Mr. Goss having sung, the function was brought to a close by the singing of the National Anthem and "Auld Lang Syne."

Reviews.

The price of books submitted for review should in every case be stated.

Questions and Answers on Midwifery for Midwives. By A. B. Calder, M.B. (Messrs. Baillière, Tindall & Cox.) Pp. xvi. and 143. 1s. 6d. net.

This is a "cram book" for the L.O.S. examination and as such seems to fulfil its purpose satisfactorily. It consists of an elaborate syllabus of the author's lectures, a very large number of possible questions with full answers, and copies of all the papers that were set between 1896 and 1904. A most useful manual for candidates for the above examination.

The Practice of Medicine. By Frederick Taylor, M.D. Pp. xvi. and 1065. (Messrs. J. & A. Churchill.) 15s. net. Seventh Edition.

The excellence of this work needs no recommendation, especially to Guy's men, who have all been brought up on it. Many additions have been made, a few being very important, and several small sections have been rewritten in this new edition, which has changed its cover from the old familiar black boards, to a dark red buckram. The epidemic at Manchester of arsenical poisoning having brought that disease prominently before the profession, its details have been embodied in a new article on the subject. The article on influenza has been rewritten entirely, as now Dr Taylor recognizes three distinct types of the disease; namely, *simple*, *abdominal and respiratory*. Many additions have also been made to the treatment of phthisis, and it is pointed out that the usual three months treatment at a sanatorium, though quite inadequate, is very useful as a training, for it teaches the patient the exact course of life he should adopt on returning to his own home.

We notice that massage is advised in some forms of dyspepsia, and that new articles appear on Sleeping Sickness and the diseases of the thymus gland. A few details are added in the clinical examination of blood, and in the chapter on Arterial Degeneration, atheroma and arterio-sclerosis are now recognised as distinct.

Many sections have been rearranged, and the book still remains the best students' text-book in the English language; it is also well known in foreign countries, for the Italian translation has now arrived at a second edition. No important facts are left out, and yet the book is a most admirable specimen of *précis* writing, as an attempt at abstraction at once demonstrates.

In Lighter Vein.

CROSS CHANNEL SWIM.

ALL RECORDS BROKEN.

(Reprinted from a Sporting Contemporary),

The greatest interest has lately been aroused in sporting circles by the announcement that a "Cross Channel Swimming Race" had been organized amongst the Staff of Guy's Hospital. Handsome prizes, a cystoscope, and a razor, all but new, had been offered by a well known New York obstetric surgeon. All the competitors had gone in for strict training, many of them under the supervision of Professor Victor. Excitement reached its climax yesterday, which had been appointed as the date of the contest. A special train was run down to Dover, minute precautions for its safety having been taken, owing to a rumour that a plot had been laid by the Southwark Board of Guardians to blow it up *en route*. Dover reached, all adjourned to the pier, where, during the interval occupied by the competitors in divesting themselves of their garments, a selection of sacred music was rendered by an orchestra, principally consisting of the Lazarus gramaphone with staccato variations from Mr. Eric Sheaf's penny whistle; a few stirring notes were also supplied on the bassoon by a gentleman, who we hear on the best authority is the Senior Casualty Officer at St. Thomas's Hospital. Mr. Higgens, the first to emerge from the comparative privacy of his dressing-room, occupied the wait by a judicious distribution of tracts. Much alarm was aroused by a shout from a small boy, to the effect that "an elderly gentleman in specs" had fallen in. A gallant rescue was effected by the Charities, who then practised artificial respiration with so much vigour, that a short rest and stimulants were required before animation was restored. On recovery, the patient, who was found to be a well known expert in forensic medicine, indignantly protested that he had only been practising a "little trick diving."

The swimmers, modestly attired in ward dressing gowns and slippers, now began to filter down to the beach, where, having been drawn

up in line, they were photographed by the Biograph amidst the admiring comments of the laity, who were rather too numerous for comfort. Special attention was paid to one gentleman who wore a swimming cap and a talc mask, speculation being rife as to who this individual might be. Upon someone treading on his bare toes, he was discovered to be the Surgical Registrar. The physical proportions of Dr. Eason were also much admired; he was wearing a Panama hat. Dr. Eyre was the only competitor who seemed thoroughly at his ease; he explained gleefully that even if his vibrio did give way again he was heavily insured south of the border, so that he really need not care a tuppenny, so-to-speak. At this juncture two important competitors were found to be missing; one of these, Dr. Horrocks, shortly appeared at the top of the cliffs; he was wearing a soft felt hat, and at once realised that he had not a minute to spare; unhesitatingly he proceeded to take a short cut down from this dizzy height by the aid of a stout rope, one end of which he cunningly tied around his waist, whilst the other end was securely held by a line of coastguards. Unfortunately the rope proved to be only half the required length, and when we went to press he was still dangling.

Mr. Lane, the other missing competitor was found seated on a rock at some distance from the pier-head; he was abstractedly admiring his bathing costume with the aid of a looking-glass. Cheers were heard from the group surrounding Sir Alfred Fripp, who had, we subsequently learnt, at that moment received a telegram from the German Emperor wishing him success.

The final preparation having been made, at a given signal all plunged into the water. The applause was deafening, and a massed band played "The Girl I left behind me." Mr. Lucas at once led off with a fine trudgeon stroke, but Anno Domini soon proved too much for him in the persons of Masters Hicks and Fagge, who quickly disappeared from view, gambolling towards the horizon like young porpoises. Each competitor was accompanied by a small row-boat containing his backers, who assiduously applied their particular sportsman with fitting nourishment. Dr. Beddard, however, swam alone, chewing a diabetic biscuit. Dr. Bryant's boat was fitted with a Marconi apparatus, and a message was received 10 hours after the start to the effect that the boat accompanying Dr. Taylor, manned by the Commissionaire, had been captured by a Russian Cruiser, whose captain, mistaking his captive for an admiral of the fleet, was demanding a colossal sum as a ransom. [Whilst printing, the news has come to us that Hancock has tossed the Russian Captain double or quits, and the latter having lost, released the Commissionaire somewhat reluctantly.]

Half-way across the Channel the Surgical Registrar deliberately fouled Dr. Eyre, whose vibrio at once gave way, and he would have sunk had it not been for the forethought and kindliness of Dr. French, who offered him his hat, into which the exhausted competitor after many futile attempts succeeded in crawling, and in this frail barque he floated, subsequently, into the harbour of Boulogne, having been caught in an awkward current.

Dr. Boycott reached land first, but was disqualified on the ground that he had walked half the way. Dr. Bryant followed him closely and was awarded victor. He modestly disclaimed any personal credit for his achievement, which he put down entirely to assiduous practice in the swimming bath attached to the Nurses' Home. Sir Cooper Perry was the last man to arrive, he had accepted his defeat very philosophically, and landed smiling on the Calais pier-head. He was met by Dr. Shaw, who, with a bow and a blink, presented him with the consolation prize—a small brick.

PULEX.

Pass List.

University of Durham, September, 1904.

FIRST EXAMINATION FOR THE DEGREE OF M.B.

Chemistry and Physics.—L. W. Evans, A. C. Greene.

Elementary Anatomy and Biology.—E. P. L. Hughes, S. L. Randolph.

Sport.

Football Fixtures, 1904-5.

RUGBY—1st Fifteen.

Oct.	8.	Lennox	Home.
	15.	Catford	Home.
	19.	Cambridge University	Away.
	22.	Rosslyn Park	Away.
Nov.	5.	Rosslyn Park	Home.
	9.	Surrey v. Middlesex	
	12.	Streatham	Home.
	19.	Old Merchant Taylors	Home.
	26.	London Irish	Home.
Dec.	3.	Richmond	Away.
	10.	Northampton	Away.
	17.	U.C.S. Old Boys	Home.
	31.	Old Leysians	Away.
Jan.	7.	Catford Bridge	Away.
	14.	Blackheath	Away.
	21.	London Welsh	Home.
	28.	R.I.E.C.	Away.
Feb.	1.	Oxford University	Away.
	5.	Racing C. of Paris	Away.
	11.	Lennox	Away.
	18.	Harlequins	Away.
	25.	Old Alleynians	Home.

2nd Fifteen.

Oct.	8.	Lennox II.	Home.
	15.	Catford "A"	Away.
	19.	Borough Road College	Home.
	22.	Norwood	Away.
Nov.	2.	St. Thomas's "A"	Home.
	5.	African Banks	Away.
	12.	Streatham II.	Away.
	16.	St. Bart.'s "A"	Home.
	19.	Civil Service II.	Away.
	26.	Old Dunstonians	Away.
Dec.	3.	Old Millhillians	Away.
	10.	African Banks	Home.
	17.	Norwood	Away.
Jan.	7.	Catford Bridge "A"	Home.
	11.	St. Bart.'s "A"	Away.
	14.	Civil Service II.	Home.
	21.	Rosslyn Park II.	Away.
	28.	Old Charltonians	Home.
Feb.	8.	St. Thomas's "A"	Away.
	11.	Lennox II.	Away.
	15.	St. Mary's	Home.
	18.	Old Merchant Taylors II.	Home.
	22.	Borough Road College	Away.
	25.	Rosslyn Park II.	Away.
Mar.	4.	Old Whitgiftians	Away.

3rd Fifteen

Oct.	8.	Lennox III.	Away.
	12.	Dulwich College II.	Away.
	15.	Kensington III.	Away.
	22.	Ealing II.	Away.
	29.	S.E.A. College	Away.
Nov.	5.	Kensington III.	Away.
	12.	Lennox III.	Away.
	15.	Epsom College	Away.
	19.	Ealing II.	Away.
	23.	Royal School of Mines	Away.
	26.	King's College Engineers II. ..	Away.
	30.	Tonbridge School II.	Away.
Dec.	3.	U.C.S. Old Boys	Away.
	7.	Royal School of Mines	Away.
	10.	Old Whitgiftians	Away.
Jan.	7.	Catford Bridge III.	Away.
	21.	London Hospital	Home
	28.	Beckenham "A"	Away.
Feb.	4.	Old Whitgiftians	Away.
	8.	Dulwich College II.	Away.
	11.	U.C.S. Old Boys	Away.
	22.	King's College Engineers II. ...	Away.
	25.	Parkhouse "B"	Away.
Mar.	4.	Blackheath School	Away.
	11.	Wasps III.	Away.
	18.	Catford Bridge III.	Away.
	25.	Parkhouse "B"	Away.

ASSOCIATION.—1st Eleven.

A trial game was held on Wednesday, October 5th, at Honor Oak. A good number of freshmen turned out, but the football was not of a very high order. It is proposed to have another game about the middle of this month, and it is hoped that as many new men as possible will turn out.

Oct.	8.	Normanhurst Druids	Away.
	12.	R. M. A.	Away.
	15.	Old Citizens	Home.
	22.	Weybridge	Away.
	29.	Reigate Priory	Away.
Nov.	2.	Casuals	Home.
	5.	Ewell	Home.
	12.	Old Reptonians	Home.
	19.	Surbiton Hill	Home.
	26.	Old Cranleighans	Home.
Dec.	3.	Beckenham	Home.
	7.	Townley Park	Home.
	10.	Kenley	Home.
	17.	South Eastern College	Home.
Jan.	7.	Beckenham	Away.
	11.	Old Carthusians	Home.
	14.	Ewell	Away.
	18.	Kenley	Away.
	21.	Croydon Park	Away.
	28.	Alleyne	Home.
Feb.	1.	Emeriti	Home.
	4.	Surbiton	Away.
	11.	Normanhurst Druids	Home.
	18.	Old Forest-hillians	Home.
	22.	St. Leonards	Away.
	25.	Croydon Park	Home
Mar.	4.	Weybridge	Away.
	11.	Westminster School	Away.

2nd Eleven.

Oct.	8.	New Beckenham	Home.
	15.	Westminster School	Away.
	22.	Old Westminsters "A"	Home.
	29.	Old Citizens "A"	Home.
Nov.	5.	Ewell 2nd XI.	Away.
	9.	Townley Park "A"	Home.
	12.	Surbiton Hill 2nd XI.	Away.
	19.	Beckenham 2nd XI.	Away.
	30.	Sevenoaks School	Away.
Dec.	3.	Croydon Park 2nd XI.	Away.
	10.	Normanhurst Druids	Away.
Jan.	7.	Beckenham 2nd XI.	Home.
	14.	Ewell 2nd XI.	Home.
	21.	Old Cranleighans	Home.
	25.	City of London School	Away.
	28.	New Beckenham	Away.
Feb.	4.	Normanhurst Druids	Home.
	11.	Central Technical College	Home.
	18.	Clapham Rovers	Away.
	25.	London Hospital 2nd XI.	Away.
Mar.	4.	Central Technical College	Home.
	11.	Alleyn 2nd XI.	Away.

Guy's Hospital Lawn Tennis Club.

In reviewing the past season, the one striking fact is our want of success—both in Club and Inter-Hospital matches. There can be no pretence that luck had anything to do with it, for the long list of defeats admits of only one explanation—want of talent. Everyone with any pretensions to being a player was tried, but with no success.

One distinct advance has been made this year, viz., the arrangement of 2nd VI. matches. There were six of these fixtures, of which three were played. In our opinion, any consistent success for the Hospital in tennis will come only when our funds permit us to play both first and second team matches regularly. There are many promising players—not quite good enough to be played regularly in the first—who get no chance of improving simply because there is no junior team where they could obtain just that extra bit of skill which makes all the difference.

Turning now to our own competitions, the entries were quite up to previous years in point of numbers. The Challenge Cup was won by F. W. M. Palmer, who is to be heartily congratulated. (We have here to offer our thanks to Mr. T. C. Lucas for returning the Challenge Cup, which he had won three times in succession, and was therefore entitled to keep). The singles handicap was divided between Mr. E. N. Jupp and Mr. Roome, who, after winning two sets each in the final, decided to share the prize. The doubles handicap was won by Messrs. F. W. M. Palmer and B. H. Wedd, the runners up being Messrs. Oram and Eccles.

The condition of the courts has been, as usual, excellent, and this opinion was fully endorsed by every team that played us at Honor Oak Park. Some new protective wire netting and uprights are much needed, and it is hoped that these will be obtainable next year. The Committee takes this opportunity to commend the ground-man, Harris, for the admirable way in which he has attended to the courts, and the excellent results he has obtained.

Little else remains to be said. The club needs the active support of all members interested in the game, and an increased grant to permit of regular second team fixtures. Given these, there is every hope of seeing the Inter-Hospital Challenge Cup back in the Smoking-room after a very long absence.

Calendar.

October, 1904.

Sat. 8.—Messrs. Symonds and Steward's take-in; Drs., W. Welchman and J. H. Mayston; Cl., J. M. Barrionuevo.

Physical Society's meeting at 8 p.m. "Some Pioneer Medical Books." Professor MacAlister. Chair to be taken by Sir Samuel Wilks.

Mon. 10.—Test Exam. in Dental Mechanics for the 1st Professional Exam. for L.D.S. Eng.

Tues. 11.—Test Exam. in Metallurgy for 1st Professional Exam. for L.D.S. Eng.

Thur. 13.—Messrs. Lucas and Lane's take-in; Drs., H. G. Gibson and T. R. Harvey; Cl., H. H. Carter.

G.H.C.U. Opening address by Dr. P. H. Pye-Smith.

Fri. 14.—Exam. in Dental Histology.

Thur. 20.—Messrs. Golding-Bird and Dunn's take-in; Drs., M. Leckie and F. A. Sharpe; Cl., M. J. Mottram.

Sat. 22.—Physical Society's meeting at 8 p.m. Clinical evening. President: G. Russell, M.B.

Marriage.

CUTLER—PHILLIPS.—On the 28th September, at St. Albans Abbey, by the Very Rev. the Dean and the Rev. A. J. Hunter, Rector of Swanton Morley and Rural Dean, Horace Arthur Cutler, M.A., M.B., B.C., of Broughton, Hampshire, fourth son of Samuel Cutler, of West Bank, Lewisham Hill, to Edith Maud, second daughter of Arthur F. Phillips, of Torrington House, St. Albans.

Deaths.

CHAPLIN.—On September 20th, at 51, Church Road, St. Leonards-on-Sea, Thomas Chaplin, formerly of Jerusalem, in his 74th year.

MARTIN—On September 14th, at Salisbury, Rhodesia, Doveton Arthur William Martin, M.R.C.S., L.R.C.P. Lond., aged 37, District Surgeon, Mwomboshi, N. E. Rhodesia.

Ed.—N. H. O.

GUY'S HOSPITAL GAZETTE.

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CONTENTS.

	PAGE.
Passim	433–435
Internal Derangement of the Knee-joint. Clinical lecture by Mr. Steward ...	436–439
From the Gazette's Special Pathologist ...	439
A Case of Nodular Epilepsy	440–441
Guy's Physiological Society	441
Appointments	441
In Lighter Vein	441–442
Guy's Hospital Christian Union	442
Change of Address	442
Pass List	442
Physical Society's Opening Meeting ...	444–450
Sport	450–451
Reviews	451–452

Passim.

THE Physical Society is to be heartily congratulated on the entire success that attended its first meeting for this session. To secure Professor Macalister to deliver the opening address was a masterly achievement on the part of the Society's officers, but that Sir Samuel Wilks should take the chair was perhaps the crowning triumph, and those who were present on this occasion, viewing the aged President of the Society, must have felt a thrill of noble emotion for their own calling, which can, in the hands of its best exponents, preserve so valuable a life to the world, and so venerable a personality to the continued respect and affection of his fellows.

A DINNER in the College Reading Room preceded the weightier proceedings in the Smoking Room below, Sir Samuel Wilks occupying the chair, and Professor Macalister being the guest of the evening. The staff was well represented, many old Guy's men being present, together with the Residents and several present students. In spite of all this, however, the dinner was uneventful, as in our opinion all dinners should be, but in this we speak but for ourselves, we have noticed that a difference of opinion exists on this point.

ON September 27th the Hospital lost one of its oldest sons, in the person of Francis Bossey, M.D., M.R.C.S., who died at his residence at Redhill, at the advanced age of 94. Born at Woolwich in 1810, he started life very humbly as dispensing assistant to a doctor in the town. During the last two years of his apprenticeship he walked to Guy's daily to attend lectures, returning by road the same night, and generally reading for lectures as he walked! Soon after this he entered the Hospital and worked under such distinguished men as Richard Bright, Sir Astley Cooper, Aston Key, Addison and Thomas Bell. In 1829 he was admitted to the practice of the London Ophthalmic Infirmary, now Moorfields Hospital, and on his succeeding his former employer in the Woolwich practice, it was in ophthalmic surgery that he specialized. He passed his L.S.A. in 1830, his M.R.C.S. in 1831, and his M.D. (Glasgow) in 1832. After practising in Woolwich for 26 years, he retired in 1858 to Worthing, and in the same year was elected a Fellow of the Royal Microscopical Society. Amongst Dr. Bossey's distinguished acquaintances, was numbered Dr. H. Y. Simpson, in whose house he witnessed some of the first administrations of chloroform. In 1865 he came to live at Redhill, where he remained till the day of his death. A correspondent, himself an old Guy's man, writes thus of Dr.

Bossey: "He was essentially one of the many men whose names bring credit to their old schools. Having outlived those who knew most of his professional ability, and nearly all those who remembered his skill with gratitude, still, his genial manner and great kindness, his absolute integrity and liberal but silent philanthropy, have endeared him to many who will keep his memory green."

It is with deep regret that we record the death of yet another old Guy's man whose name will be familiar to many who were at the Hospital in the eighties and nineties. Doveton Martin was one of the most popular men of his day, especially in the sporting circles. We believe we are right in saying that he was at one time champion middle-weight boxer and his prowess in the ring was greater than that of any other Guy's man before or since his time. He qualified in 1896, and one of his first locums was in a South Wales colliery district, where he worked like a Trojan and made himself very popular with the miners. In 1900 he left England for Rhodesia to take on the duties of Medical Officer at Fort Salisbury. Here he did splendid work and enjoyed the best possible health, writing home enthusiastically of his practice and of the life out there. In a letter to his father, dated August 11th of this year, he announced his approaching visit to England on his first furlough, and the next news of him was the cable announcing his sudden death whilst actually on his journey home. Up to the present the particulars of his death are not to hand. We should like to express, in the name of all Doveton Martin's many friends, the deepest sympathy with his relations in their terrible bereavement.

The Annual Meeting of the Students' Club will be held on Thursday, October 27th, at 4.30 p.m. in class room No. 1 of the Surgical Buildings. Dr. Pye-Smith will occupy the chair, and the main business will consist of a discussion of the budget and the balance sheet for the past year. The last general meeting was exceedingly well attended, and it is hoped that there will be no falling off in numbers on this occasion. We have constantly urged in these columns that it is nothing less than the bare duty of all members of the club to attend the general meetings. The work of the committee is of an exceedingly thankless nature, and a good attendance of members taking an active interest in their club's welfare is one of the small returns that that club can make to those who so carefully direct its destinies. We have it from no less a personage than the secretary of the club that even a little organized opposition "will receive the sympathetic attention of the committee," and we counsel all intending malcontents to earnestly consider the college wall paper, and if in that nightmare of colour and design they do not find inspiration enough for a most frenzied protest, then the æsthetic side of the Guy's man is not as pronounced as we had thought. For our part we counsel all those who are willing to take "wall paper" as their battle cry to go up to Ramoth Gilead and prosper.

The Baby Show which was held at the Charterhouse Mission, Crosby Row, on Thursday afternoon last, was a spectacle which no properly constituted Guy's man could witness unmoved. All our little friends of the surgery and the district were there in full force, and considering the formidable nature of the examination and the terrifying demeanour of the judge (Mr. H. T. Hicks) and his accomplices, they really behaved remarkably well. The show was not without incidents of an unexpected nature, particularly towards the finish, when, on the name of the winning competitor being proclaimed, a well known surgeon (whose voice, were this in any other than a sober column of the Gazette, one would usually describe as rasping) was heard to exclaim "There's some mistake, he's got a tracheotomy wound in his neck. I did it myself." Either the judge had overlooked the extensive scarring that must have been present if this distinguished surgeon was correct, or else it was only another instance of the latter's love of creating a sensation for its own sake, for in any case the judge took no notice of the interruption. At the conclusion of the show, Canon Horsley made an unusually interesting speech on infant mortality, but the judge had discreetly disappeared.

In the *Engineer* for October 14th, the first of a series of articles on Engineering at Hospitals makes its appearance and it is gratifying to see that Guy's is the first hospital discussed under this head. "It so happens," says the *Engineer*, "that at Guy's Hospital a remodelling of its engineering equipment has recently been completed. There has been installed there that which is probably the best designed and most efficiently arranged engineering plant possessed by any hospital." Here there follows a technical discussion of the nature of the plant. It is proverbial that lookers-on see most of the game, and certainly it would be true to say that there are very few men in the Hospital, other than the officials immediately concerned, who have the remotest conception of the intricate nature of the engineering side of this institution, and the only time when remark is made, as regards the working of this or that apparatus, is on the comparatively rare occasions when something has gone wrong. The article gives a short resumé of the events which led up to the decision of the Governors to generate their own electricity rather than depend any longer on the current of a supply company, and also tells of the difficulties those same Governors have successfully grappled with in dealing with the question of water supply. There are other incidental achievements of our resident engineer, Mr. Barnes, which might well be recorded—such as his thorough appreciation of the ins-and-outs of stage lighting (particularly his management of moonlight effects!)—and also that, to his eternal credit, he knows where a spring board in a swimming bath is useful and where it is useless. Altogether the article is a most interesting one, and calculated to stop the mouth of the ignorant critic who is usually to be heard when things are not going quite as they should do. No mention is made of the Guy's telephone we notice—perhaps another instance of a profane silence.

On November 9th, the Oxford and Cambridge men at Guy's Hospital will dine together at the Bridge Hotel. Dr. Pitt will occupy the chair. All 'Varsity men are particularly requested to keep this date open, so that a good muster may be ensured.

The Residents have decided on November 22nd as the date of their Dance, which is to be held, as usual, in the Court Room. This is usually one of the most enjoyable of all the winter festivities and functions, and we have no doubt that the coming dance will be no exception to the rule.

Messrs. Trail, O'Brien, Morgan, McEvedy and Saunders, the Guy's contingent of the Anglo-Australian football team, have at last returned to a welcoming hospital, and many are the anecdotes which each has to tell of their cordial reception at the hands of the colonists. Generally speaking, our men proved themselves well worthy of their places in the team, and in the second test match against Sydney, all the five were included in the English fifteen. In nearly every town on their tour Guy's men made it their business to meet the representatives of their old hospital. Dr. Alfred Martin, of Wellington, entertained them, together with several of the leading medical men of the town. In this case their host, a contemporary of several members of our senior staff, was full of stories of past days, and enquired after all his old friends. At Christchurch they met F. G. Gibson, at Wanganui, A. H. E. Wall, at Dunedin, C. Batchelor, and at Timaru, R. B. Hogg; at Brisbane also they met E. R. Row and George Lewin. The team returned via Fiji and Honolulu, and having crossed Canada, paid a visit to Niagara and New York.

It is a pity that of this dauntless five, McEvedy and Saunders should be the only two eligible for Cup matches, the other three being out of their year. Our team, as it is, could do with a lot more stiffening, the forwards being specially weak. The Lennox match was a good start, but of the team's visit to Cambridge, perhaps the less said the better. Our prospects as regards the recapture of the Cup are gloomier than ever, but we have no doubt that the team will strain every nerve towards this end, and will at least preserve our reputation in the Rugby field.

Internal Derangement of the Knee-joint.

CLINICAL LECTURE BY MR. STEWARD.

Gentlemen,—The term, Internal Derangement of the Knee-joint, was first used by Hey, many years ago, who applied it more especially to cases of displaced semilunar cartilage, in which sense the term is often still used.

I think, however, that it is more convenient to include, in addition, loose bodies, pedunculated bodies, and so forth, under the same heading, because clinically all these conditions belong to the same group of cases. The term internal derangement is not a very satisfactory one, and requires a little explanation perhaps. The word *derangement* is used really in contradistinction to active *disease*, and by it is meant a *mechanical* derangement which results in *mechanical* interference with the functions of the joints. The derangement, it is true, may be the result of disease, but the mechanical interference with function does not necessarily mean *active* disease in any way—that is the point.

In all these cases the essential point is that something is loose that ought not to be, and consequently tends to become at times caught or jammed between the bones, so that the patient is suddenly seized with more or less intense pain in the joint, which at the same time becomes more or less fixed or locked.

The principal causes of internal derangement are :—

I. *Loose bodies* which may originate in any of the following ways :—

1. A mass of fibrin that has become loosened and condensed.
2. Blood clot that has undergone similar changes.
3. A thickened synovial fringe that has been torn off.
4. Detached osteophytes or marginal cartilaginous out-growths in traumatic or osteo-arthritis.
5. A piece of exfoliated cartilage.
6. A piece of cartilage, or even bone, detached by injury.
7. Fibrin deposited round a foreign body, *i.e.*, needle.
8. Tuberculous loose bodies.

II. *Pedunculated bodies*, which are usually the result of injury to a synovial fringe leading to infiltration with inflammatory products. They may also be caused by hæmorrhage into a fringe, and again occur as cartilaginous masses in osteo-arthritis, or even may result from slight tears of the semilunar cartilages.

III. Thickened synovial fringes, the result of injury or inflammation.

IV. Torn semilunar cartilages.

The following cases will serve to illustrate these points :—

Case 1.—The first is a case of loose body in the knee-joint. T. C., æt. 22, was admitted into Job in December, 1902, with the following history. Six months before he strained his knee while playing cricket. Next morning the knee was considerably swollen. The swelling disappeared in a few days and patient then discovered that he had a loose body in his knee-joint. Subsequently on several occasions he had had sudden excruciating pain in the joint, which became momentarily locked at the same time. On each occasion slight synovitis followed these attacks. On admission, a loose body was easily discovered in the joint, otherwise the knee appeared normal. Under an anæsthetic I was able to work the loose body up into the supra-patellar pouch and there fix it with a needle. It was then easily removed through a small incision in the extensor tendon. The loose body was in size and shape very like a broad bean and consisted of a hardened mass of fibrin.

Case 2 was a nurse who frequently, whilst about her duties, experienced sudden pain in the knee, which gave way under her at the same time, so that she almost fell down, and I believe she did actually fall on several occasions. Slight synovitis usually followed these attacks. The pain was always referred to the outer side of the patella. I carefully examined the knee after several of these attacks, but beyond the synovitis I could discover nothing. One day, however, when no fluid was present I luckily felt something distinctly slip from under my finger at the outer border of the patella, just where the pain had always been. On the strength of this I opened the joint and found a small body, not larger than a pea, attached by a long pedicle to the ligamentum alarium on the outer side. This was snipped off and the wound closed. The patient now does her work in the wards and has had no further attacks. Here, then, the derangement consisted of a pedunculated body, due no doubt to injury and effusion into the ligamentum alarium, and which swung on its pedicle underneath the patella and so was nipped between the patella and femur and caused the sudden attacks.

Case 3 is somewhat similar to the last. A young girl was sent to me with a history of the

knee suddenly giving way under her at frequent intervals. On each occasion the knee was painful, especially at the outer side, for a day or two afterwards, and *sometimes* it was swollen. She was sent to me after a more severe attack than usual. There was then considerable synovitis. When this had subsided under treatment I was able to make out something that slipped about, and was a little tender, situated on the outer side of the patella. I took her into Lydia and explored the joint and found a loose, almost pedunculated fold of synovial membrane attached along the prominent anterior edge of the outer condyle. This fold could easily be pushed under the patella, and this was no doubt what happened when the patient experienced the sudden "giving way" of the knee. The fold was removed and the wound closed. This was about nine months ago and as the patient has had no further trouble I think I can say that she is cured.

I now come to those cases in which the cause of the derangement is due to injury of one of the semilunar cartilages. The trouble in these cases dates from a severe wrench as a rule, the cartilage being torn to a greater or lesser extent from its attachments and so becoming more or less loose. The internal cartilage is almost invariably the one affected, but in very rare cases it is the external one. In all my cases the internal cartilage has been involved. I have selected three cases as being fairly typical of the conditions met with.

Case 1.—A Guy's student, well known to many of you, came to me in August 1900, with this history. Seven years previously he wrenched his knee at football, the joint becoming locked. It was "put in" by manipulation, or in other words, forcible movements were made and resulted in the joint suddenly becoming free. This was followed by severe synovitis. Subsequently the same thing happened on frequent occasions, in spite of bandages and appliances, each attack being associated with severe pain over the site of the internal semilunar cartilage and locking of the joint. Moreover, the attacks had become more and more frequent and occurred more and more easily, so that when he came to me he told me that even stepping off a kerb was sufficient to cause the displacement. I decided to operate, and found that the cartilage was torn from its anterior attachment and also to a large extent from its marginal attachments. At the operation the displacement that took place was demonstrated most perfectly, for, in order to examine the cartilage after I had exposed it, I gradually flexed the joint, when suddenly there was a snap and the cartilage flew back and disappeared behind the internal condyle. No attempt was made to fix the cartilage, which was completely removed, the capsule being then sutured and the wound closed. Recovery was uneventful and six months later the knee was as good as the other one, so that after another year the patient was able to play football, tennis, etc., and has been able to do so ever since.

Case 2.—Also a Guy's man, and one of our prominent athletes, had a somewhat similar history. I will read his history which he has kindly written out for me:—

"*History.*—November, 1899. First accident, displaced semilunar cartilage, much pain and considerable effusion; rested a week. Following this strain endeavoured to start football again a week afterwards, and had a very severe wrench which necessitated laying up for quite six weeks. The knee was very tender and swollen and for two days I was unable to rectify the position of flexion and fixation; reduction was made by manipulation! During the past four years I have had continuous trouble with the left knee, displacement on slightest provocation, even with support from various appliances.

"January 12th, 1903. Entered Bright ward.

"13th. Operation on knee.

"23rd. Wound dressed and stitches removed.

"February 4th—7th. Croft applied, and on following day cut up down the outside. At this time, too, I first left bed.

"8th—10th. Left the ward on crutches which were really not necessary, and at about same time started passive movements and massage myself.

"In another three weeks entirely discarded splint, no support to limb necessary.

"June, 1903. Bowled throughout cup ties."

On exploring the joint, I could at first find no internal semilunar cartilage at all, but discovered it afterwards tucked away into the intercondyloid notch. It was attached at its extremities, but torn away from its marginal attachments, and had turned completely over, like the handle of a bucket.

I have operated on three cases in which a precisely similar condition existed, in each case the cartilage being much thickened and lying in the intercondyloid notch. The result was quite satisfactory, as you may judge from the final remark in his account.

Case 3.—This case differs from the others only as regards the condition of the cartilage. The first injury occurred on board ship, the patient falling and wrenching the knee. After

this frequent lockings and subsequent attacks of synovitis occurred as in the other cases.

At the operation in April, 1903, I found the internal semilunar cartilage itself torn, or rather split, in this wise (diagram), so that the inner part was quite movable.

This inner part was removed and the wound closed. The knee has since been perfectly sound.

These three cases illustrate the chief forms of injury to which the internal semilunar cartilage is liable. To refer to them again for a moment they are as follows.

Most commonly, I think the marginal attachments are to a greater or lesser extent torn, allowing part of the cartilage to slide inwards, or, as in case 2, allowing the whole cartilage to turn right over like the handle of a bucket and become lodged in the intercondyloid notch.

Frequently the anterior attachment is torn across as well, so that the cartilage flies backwards when the joint is flexed, as it did in case 1. More rarely the inner edge of the cartilage is split off, as in case 3, the part split off varying in width. Finally, a little bit of the inner edge may be split off and become thickened into a little pedunculated mass, which is liable to become caught between the bones.

Symptoms and history. —The symptoms and history you will have gathered from the clinical histories that I have read to you.

They are:—

1. History of an *initial* injury.
2. Sudden attacks of pain, associated with—
3. Locking of joint, and followed by—
4. Subsequent synovitis.

1. There is sometimes no definite history of injury, but this is rare. The history is usually quite definite, especially in the cases of torn semilunar cartilage. This is what one would expect, because a fairly severe wrench is probably necessary to tear the attachments of the semilunar cartilages, whereas quite a slight injury may cause sufficient damage to the synovial membrane to produce a polypoid body or loose body.

2. The *pain* varies, but is nearly always severe, and sickening in character. When the cause is a quite small polypoid body, as in case 2, pain is, however, sometimes little complained of.

3. *Locking.*—This will vary in degree also. If a loose body of considerable size or part of the semilunar cartilage becomes jammed between the femur and tibia the joint may be firmly locked and there may be much difficulty in releasing it. On the other hand, a small fringe nipped between the patella and front of the femur does not necessarily give rise to locking recognised as such, but as in cases 2 and 3 generally causes slight locking, which is described by the patient as sudden "loss of power," "giving way," etc.

4. *Synovitis.*—This again, as you would expect, varies with the severity, but normally occurs in some degree after each attack. The time it lasts will of course vary with the treatment adopted for it. It should be noted, moreover, that as a rule the severity of the synovitis tends to become less as the displacement becomes more frequent. One might add to these symptoms the fact that there is usually a sense of insecurity in the limb, which tends to become more marked, as one would expect, as the attacks become more frequent and easily produced.

The *Diagnosis* is practically founded on the history and symptoms, so that as regards the general diagnosis of internal derangement I need say nothing.

As regards the diagnosis of the form of displacement, the following points are of importance:—

1. Site of pain, and tenderness. A careful investigation of this point will often help largely to determine the form of derangement present. Where the pain and tenderness are constantly referred by the patient to the site of one or other semilunar cartilage, the cartilage is almost certain to be the cause of the trouble. If the tenderness is elsewhere but nevertheless constant as to site, a pedunculated body or thickened synovial fringe may be presumed to be present. On the other hand, should the site of pain and tenderness constantly change, there is probably a loose body present in the joint.

2. The degree of pain and locking. If very severe pain and marked locking occur at each attack, it is probable that the derangement is due to an injured semilunar cartilage or a loose body of considerable size, which becomes firmly wedged between the bones when the attacks take place. On the other hand, as illustrated by the cases I have described to you, the slighter attacks are more likely to be due to small pedunculated or loose bodies, or fringes, and so forth.

3. The result of careful examination. Examination will often be negative as regards the determination of the cause of the derangement, especially when synovitis is present. But if the joint is carefully examined between attacks, it

will often be possible to feel a loose body, or a polypoid body, or a fringe as I have described to you in the cases. Moreover, the patient will frequently tell you that he has felt something himself, as in Case 1.

On the other hand, torn semilunar cartilages cannot be felt, as the displacement takes place away from the surface and towards the centre of the joint. It may occasionally, however, be possible to make out a depression over the site of a displaced cartilage, but this is seldom the case because the torn edge of attachment becomes thickened to some extent, so that the absence of the cartilage from its normal position will not be noticed.

Treatment.—If it is certain that some form of mechanical derangement is present, as shown by repeated attacks, such as I have described to you, I believe that in the great majority of cases the wisest and most satisfactory course is to deal with the condition by operation, provided always that this can be done under the best possible conditions as regards antisepsis. If these conditions can be ensured and the patient is otherwise in good health, the operation is a comparatively slight one and is attended by most satisfactory results. I say comparatively slight advisedly, because I would take this opportunity of impressing upon you that I refer only to the operation itself, which is not attended with any great difficulties. The responsibility, as regards preliminaries, is a grave one, for as you know, accidental infection of the knee-joint is a most serious thing and will probably result in a stiff limb if not in amputation.

The operation itself in the case of loose bodies, pedunculated bodies and so forth consists merely in an incision over the site of the offending structure, the removal of whatever is found, and suture of the wound.

For the exploration of a damaged semilunar cartilage various incisions have been employed. I now always make use of a curved incision with the convexity downwards. A flap is turned up from the inner surface of the joint, and a transverse incision then made through the periosteum along the upper margin of the tibia. The capsule of the joint is then turned upwards and the site of the cartilage inspected from below. This plan, I consider, gives much the best access to the parts and enables the operator at once to determine the condition of the cartilage.

Having determined the extent of the damage, the next step is to remove as completely as possible the part of the cartilage that has been torn away. I always do this in preference to suturing the portions together, because the results are perfectly satisfactory and there is no fear of sutures giving way afterwards and so leading to recurrence of the trouble. Moreover, as no sutures are left in the joint, one of the chief causes of infection is eliminated.

The divided periosteum is now stitched up with a few interrupted sutures, and the skin flap replaced and sutured.

As regards *after-treatment*, the limb should be kept at rest on a splint for a fortnight, a plaster of Paris case may then be applied, and the patient be allowed to get about. After another fortnight the splint may be gradually discarded, provided that no pain or synovitis are present, the splint being left off for a few hours per diem only at first, and the time gradually increased, so that at the end of another week the splint may be left off altogether.

After the first fortnight, massage will be found most useful, especially for the thigh muscles, which usually waste considerably. One last point I would like to impress upon you, and it is, that it is quite unnecessary to move the joint for the patient. As the splint is discarded and the limb is used more and more, free movement will be found to return quickly and satisfactorily, whereas passive movements, especially if at all violent, are more likely than not to cause troublesome synovitis.

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Tuesdays, October 25th and November 1st, 1.15 p.m., Clinical Surgery, by Mr. Clement Lucas.

Saturdays, October 22nd, 29th and November 5th, 1 p.m., Clinical Medicine, by Dr. Hale White.

Monday, October 24th, 1.15 p.m., Lecture by Sir Cooper Perry.

Monday, October 31st, 1.15 p.m., Lecture by Mr. Targett.

From the Gazette's Special Pathologist.

NOTICE.

G. McG., Portsmouth.—The fluid is faintly acid in reaction, and has a specific gravity of 1006. It is free from albumen and sugar.

The centrifugalised deposit is small in amount, and consists of vaginal squamous cells with extraneous bacteria, and a few leucocytes.

No red blood discs, tube casts, renal cells or crystals are noted. Urea is present to the extent of 0·3 per cent., or 1·3 grains per ounce, and an appreciable quantity of uric acid is detected. The specimen has the characters of dilute urine. PATHOLOGIST.

A Case of Nodular Leprosy.

From the Leper Asylum, Pretoria.

Ratan, a single Shargaan girl, aged about 15 years, since she was 5 years old when the battle of Maraçuenne was fought. She was born at Maparenquene, Delagoa Bay, and came in from Pilgrim's Rest, Lydenburg district, Transvaal.

Father = Maxla, dead, cause unknown.

Mother = Maguayan, dead, cause unknown.

(*a*) Umbowen (×) husband, alive and well, no children.

(*b*) Boy, name unknown, died when patient was a child.

(*c*) Girl, name unknown, died when patient was a child.

(*d*) Patient.

In 1899, when she was living at Delagoa Bay, she noticed lumps on her face.

No history of leprosy in her family, and she says she has never seen any lepers.

Has never eaten fish of any kind.

Present condition.—Plenty of hair, no eyebrows, eyelashes scanty. She can close her eyes and can whistle. Her face and ears are covered with prominent lepromes.

On her back thickenings of the subcutaneous tissue can be felt which are not visible as lepromes, the same condition exists on her arms.

Right hand.—Finger nails and movements normal.

Left hand.—Finger nails and movements normal.

Right foot.—Superficial ulcer on tendo-Achilles. All toes present, sensation normal.

Left foot.—All toes and nails present, sensation normal.

First and second toes enormously enlarged.

First, circumference 5⅝ins., length 3ins.

Second „ 3⅞ins. „ 2½ins.

Foot in this condition as long as she can remember.

Patient says this condition has existed since she can remember.

This is a well marked case of nodular leprosy, no symptoms of nerve trouble could be discovered though carefully sought. Anæsthesia is usually first manifest over the elbows and the patellæ, while motor paralysis is commonly first met with in the hands. The tip of the thumb can not be made to touch the base of the little finger of the same hand. Sometimes there is no evident loss of muscular tissue, though usually the thenar and hypothenar muscles are flattened. On post-mortem examination there is frequently an entire absence of muscular tissue, but the shape and size has been preserved by an accumulation of fat and fibrous tissue.

Paralysis of the orbicularis palpebrarum, and of the orbicularis oris is often met with early in the disease, especially in the anæsthetic variety.

It is exceedingly difficult to obtain a satisfactory history from coloured patients, such as are known as "Raw Kaffirs." In the first place, they never know how old they are. Their age can only be estimated by their knowledge of past events, such as battles, cattle plagues, etc.

In this instance the patient remembered the battle of Maraçuenne, when Gungunhama was captured. It was fought in the district in which she was born, and she indicated her age by showing me how tall she then was.

That at some time or another she had associated with lepers is very probable, despite her denial. This does not imply that she wished to mislead me. The majority of lepers here suffer from the anæsthetic form and easily escape detection. I have had many lepers under my care from her country, but, to the best of my recollection, she is the first well marked case of nodular leprosy from that particular district.

With care and perseverence, however, much more can be obtained, in the way of family history, than one would at first suppose. During three years I have been able to test the accuracy of accounts I have received from Kaffir patients. Frequently other members of the family have come under my care, and very often I have re-examined patients after the lapse of a year or eighteen months.

The stories related by different members of the same family have been very concordant, and the same may be said of the re-examinations. With respect to the latter it is impossible to suppose that the patients, after such a long interval, would recollect, names, etc., supposing that their first accounts were based on their untutored imagination.

The question as to the consumption of fish is simply routine, and has been addressed to every leper since Mr. J. Hutchinson started his fish theory of the origin of leprosy.

The vast majority of lepers in this country have never even tasted fish of any description. The Zulu usually spits on the ground to express his disgust when questioned on the subject.

Mr. Hutchinson relates an extraordinary tale of finding a Kaffir fishing in Natal. No doubt his statement is correct, but the incident is simply extraordinary. I have lived in South Africa ten years, I am fond of fishing, I have been all over the country from Cape Town to Bulawayo, and from Durban to Port Nolloth, besides going up the Mamati River from Laurenco Marques, but I have never yet seen any colored native fishing.

Besides, it has been my misfortune to see children become lepers, who, I know, cannot possibly have tasted fish of any kind.

The description of the onset of the disease is that usually given by patients suffering from the nodular variety. There is generally a history of a sudden attack accompanied by feverishness, and is usually attributed to cold or exposure. The onset of the anæsthetic variety is much more insidious, and is often difficult to diagnose.

An Englishman was once sent to me who had been treated for years for a skin disease (pemphigus) by many well known and able men, and who was actually passed into a volunteer body of horse, and fought during the late war. After the corps he belonged to was disbanded, he returned to Johannesburg and was again treated for his skin

disease, while he followed his usual occupation. His condition was only discovered because it became necessary to amputate his left index on account of an accident, a burn. He then mentioned that he did not require chloroform because he could not feel.

I am sending the photograph of this patient on account of the condition of the left foot. The size of the first and second toes can have nothing to do with her leprosy. The toes have been large as long as the girl can remember and the deformity is probably congenital.

My knowledge of acromegaly is, however, nil, I only know it from books, never having met with a case; still I think it well to bring the condition before your readers, who are naturally in a better position than I am to offer an opinion.

GEORGE TURNER.

Guy's Physiological Society.

The general meeting of the above society was held on the 6th October. It was well attended, many new members being present.

A vote of thanks was passed to the outgoing honorary secretary and treasurer, Mr. G. F. Stebbing, for the keen and able manner in which he had conducted the affairs of the society during the session 1903–4.

Dr. Pembrey was unanimously re-elected president, whilst Drs. Beddard, Spriggs and Forsyth were again elected vice-presidents. Mr. J. H. Ryffel was added to their number.

The honorary secretary and treasurer for the ensuing year is Mr. P. S. Price; and the committeemen, Messrs. Carr, Giesen, J. Smith, Watson and Mandel.

Many interesting papers have been promised by the members, and the coming year promises to be successful in every way.

The next meeting of the society is to be held at four o'clock, Thursday, 3rd November, in the Physiological Buildings, when Mr. P. Seymour-Price will read a paper on "Physical Degeneration."

Appointments.

Naval and Military.

Surgeon E. S. Tuck, R.N., is promoted to be Fleet Surgeon in His Majesty's Fleet.

Staff Surgeon Laurence Bidwell, R.N., has been appointed to the *Hogue*; Surgeons Gordon Moir, R.N., to the *Fire Queen*; Hugh B. German, R.N., and Gerald Nunn, R.N., to the *Vivid*; and Frank R. Featherstone, to the *Pembroke*: all for disposal.

Lieutenant-Colonel P. A. Weir, M.B., I.M.S., is confirmed as Administrative Medical Officer, North-West Frontier Provinces, from June 25th.

In Lighter Vein.

TWO DIALOGUES.

Scene. Out-patient Department, in the "dog" days of Summer.

I. The Real.

An Out-Patient: 'Ere, I say, aint yer goin to do me next? Never mind 'im, I come ere fust. I'm a van driver, thats what I am, and I've been waiting in this bloomin' place ever since arf-past nine! ever since arf-past—

Assistant Dresser (sharply): Hold your tongue, there.

A.O.P.: Beg parding me lord; if I'd a knowed it was you I would not have breathed without askin leave.

A.D.: Now, what is the matter with you?

A.O.P.: That's what I want to know.

A.D. (impatiently): Well, what have you done to yourself?

A.O.P.: Aint done nothin.

A.D. (desperately): Why on earth are you here?

A.O.P.: 'Urt me arm.

A.D.: How did you manage that?

A.O.P. (showing septic wound): It managed itself somehow.

A.D.: Take your hat off.

A.O.P.: Crikey! Carnt you put anyfing on me arm unless I tike me 'at off?

A.D. (severely): No.

A.O.P. (sarcastically): If I 'ad somethin in me eye, you would make me take me boots off, I suppose!

A.D. (with a shudder at past experiences): Oh, no thank you!

A.O.P. (as dresser applies H.B.F.): Take it orf, its too 'ot.

A.D. (parrot-like): The heat draws out the inflammation.

A.O.P.: It will draw out me skin in a minute. (With sudden politeness), Thank you very much, Sir; will you give me a certificate, please?

A.D.: What for?

A.O.P.: Well, Sir, I am a van-driver and I carnt drive no osses with me left arm all swelled up like this.

A.D. fills up form and gives it to patient.

A.O.P.: Thank— (suddenly returns to original manner). Wy, it aint signed.

A.D.: You must ask the House-Surgeon to do that for you.

A.O.P.: Oo's 'e?

A.D. : That gentleman over there.

A.O.P. : Wot, *that* little chap?

A.D. (with necessary emphasis) : Yes, that gentleman over there.

A.O.P. (aggressively) : Ow!

N.B.—If this patient gets well, he will say it is because he has "good healing flesh." If he gets worse, however, he will say it is because he was not properly treated.

II. The Ideal.

Assistant Dresser (genially) : Well, and what is your trouble?

An Out-Patient (gratefully) : It is very kind of you to ask, Sir, you have been so busy that you must be tired, and mine is such a trifling ailment that I think I will go home and attend to it myself.

A.D. : No trouble at all, it is my duty; I am sorry that you have almost had to wait.

A.O.P. : Don't mention so small a matter, Sir, it is a pleasure to watch your deft ministrations to the sick and ailing—(shows septic wound on arm).

A.D. (shocked) : Oh, my poor fellow! What a terribly bad arm you have, how you must have suffered.

A.O.P. (piously) : I must not complain, it might have been much worse.

A.D. (aside.) : The heroism of the working classes—(Aloud) I will foment that for you.

A.O.P. : Thank you kindly, Sir; do not trouble to get those expensive things for me; a piece of warm, wet lint will do nicely.

A.D. (tenderly) : Be sure to tell me if it is not just as you like it. Are you sure the lint is neither too hot nor too cold, and not too wet or too dry?

A.O.P. : It is splendid, and if you will excuse the liberty, how beautifully you bandage.

A.D. (modestly) : It is quite easy when you are used to it. Now you will want a certificate.

A.O.P. : I would rather go to work if possible, Sir.

A.D. : What is your work?

A.O.P. : I am a van driver.

A.D. : You cannot possibly drive whilst your left arm is in that condition; you must go on the sick list for a time and draw full pay.

A.O.P. (with saint-like resignation) : Alas! It goes sorely against the grain to spend money which I have not earned, but I suppose I must bow to the inevitable.

A.D. : I think you are too sensitive.

A.O.P. : Ah, Sir, it has been my lot in life to ever sigh for the unattainable. When I drive on my daily rounds I am within an ace of all that is enviable in earthly bliss; I am only separated by one frail barrier from untold joys.

A.D. : I do not understand.

A.O.P. : I am the driver of a brewers' van, Sir.

"THE WANDERING JEW."

Guy's Hospital Christian Union.

The opening meeting of the Christian Union for the session was held on Thursday, October 13th. Dr. P. H. Pye-Smith, F.R.S., very kindly took the chair. Mr. C. W. G. Taylor, M.A., spoke very well on the value of a Christian Union.

The chairman then gave a most practical address, incidentally remarking that Christianity is not incompatible with science, for he was pleased to be able to tell those present, that with very few exceptions all the Presidents of the Royal Society had been earnest and devout Christians, instancing Sir Isaac Newton, Professor Stokes and Sir William Huggins.

Change of Address.

Mr. R. P. Rowlands, from Guy's Hospital College, to 6, St. Thomas Street, S.E.

Dr. J. B. C. Brockwell, from the Poplar and Stepney Sick Asylum, Bromley-by-Bow, to 42, The Parade, Walton-on-Naze, Essex.

Dr. S. G. Floyd, from 31, Rosenthal Road, Catford, S.E., to Lister House, Grays, Essex.

Dr. A. G. Osborn, from 27, Cator Road, Sydenham, to Clifton House, Sheet Street, Windsor.

Dr. A. J. Sharp, from Whitby, Yorkshire, to Newlyn, Fishpond Drive, The Park, Nottingham.

Dr. E. J. Tongue, from Edenbridge, to Rocklands, East Grinstead, Sussex,

Dr. Frederick Vicars, from Richmond Hill, Bournemouth (travelling).

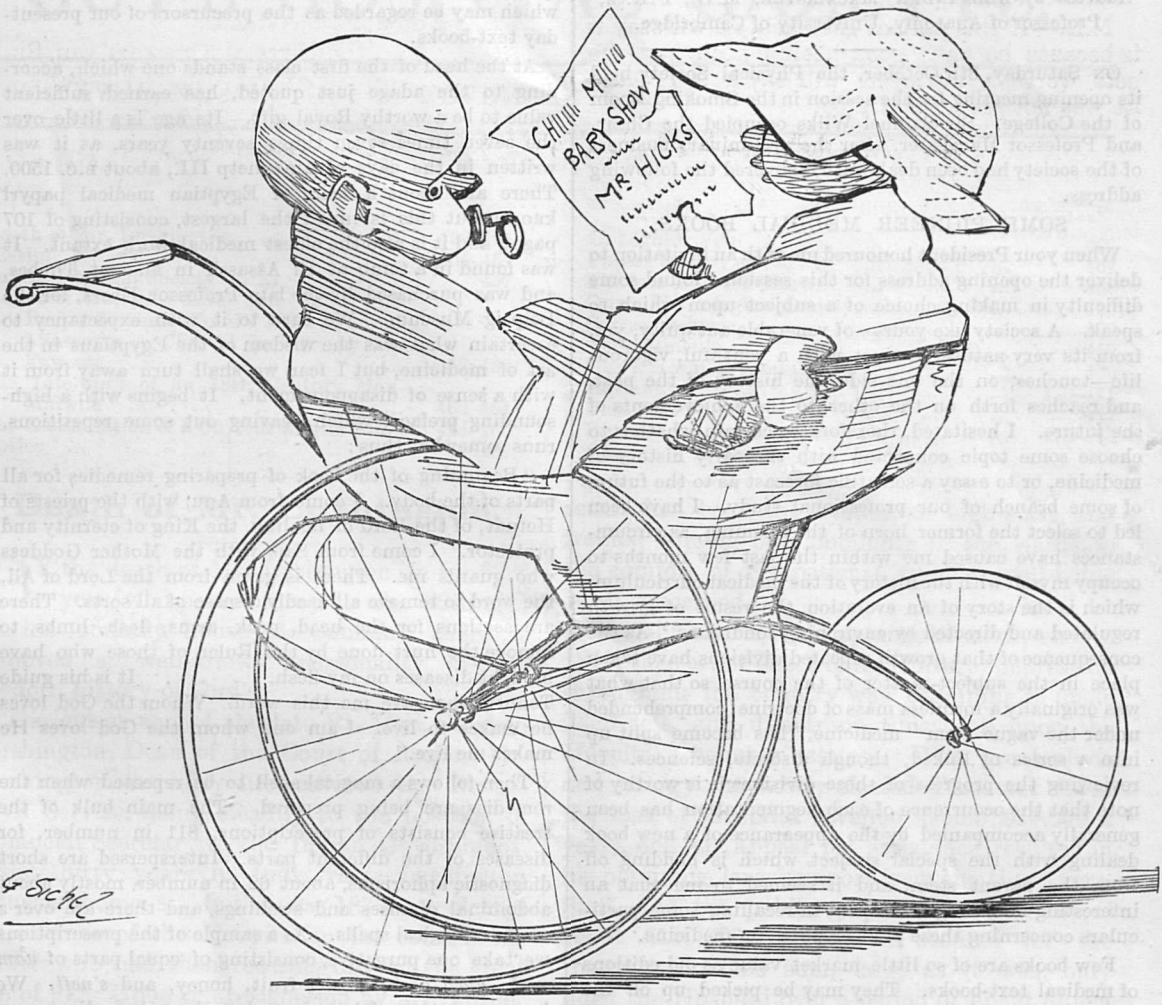
(The Editor will be very glad to receive a postcard with notes of any change of address.)

Pass List.

University of Cambridge, October, 1904.

EXAMINATION IN SANITARY SCIENCE.

E. G. Allport, R. D. Smedley.



The Crisis in the Boro'.

"'ERE! 'ICKS! 'OO'S 'ICKS!!"

[On Thursday, October 20th, a Baby Show was held in connection with the Charterhouse Mission, Crosby Row. Mr. H. T. Hicks, kindly officiated as judge.—*vide* Daily Papers.]

Physical Society's Opening Meeting.

Address by Alexander Macalister, M.D., F.R.S.,
Professor of Anatomy, University of Cambridge.

On Saturday, 8th October, the Physical Society held its opening meeting for the session in the Smoking Room of the College. Sir Samuel Wilks occupied the Chair, and Professor Macalister, after the preliminary business of the society had been dealt with, delivered the following address.

SOME PIONEER MEDICAL BOOKS.

When your President honoured me with an invitation to deliver the opening address for this session I found some difficulty in making choice of a subject upon which to speak. A society like yours—of venerable antiquity, yet, from its very nature, instinct with a youthful, vigorous life—touches, on the one side, the history of the past, and reaches forth on the other, to the achievements of the future. I hesitated, therefore, uncertain whether to choose some topic connected with the early history of medicine, or to essay a scientific forecast as to the future of some branch of our professional study. I have been led to select the former horn of the dilemma, as circumstances have caused me within the last few months to occupy myself with the history of the medical curriculum, which is the story of an evolution, the result of growth regulated and directed by environing conditions. As the consequence of that growth repeated divisions have taken place in the subject-matter of the course, so that what was originally a formless mass of doctrine, comprehended under the vague term "medicine," has become split up into a series of linked, though discrete, sciences. In reviewing the progress of these divisions it is worthy of note that the occurrence of each segmentation has been generally accompanied by the appearance of a new book dealing with the special subject which is budding off from the parent stem, and it seemed to me that an interesting hour might be spent in recalling some particulars concerning these pioneer works on medicine.

Few books are of so little market value as old editions of medical text-books. They may be picked up off the barrows of the street vendor for fewer pence than they originally cost shillings, and, in general, they are not worth buying even at that small outlay. But there is a certain stage of antiquity at which a book begins to acquire a new value in accordance with the old rhyme:

> Keep a thing for seventy years and it a price will bring;
> Keep it seven times seventy years, it is a precious thing;
> But keep it seven times that again, and give it to the King.

It is mainly of books whose value is thus enhanced by age, as well as by circumstance, of which I desire to speak this evening.

"Of the making many books there is no end." Even if we confine ourselves to the subject of pioneer books as defined just now, our catalogue will prove to be too long. We shall therefore require to limit our selected series, and I propose to take these in three groups: first, the most ancient series; secondly, an intermediate group, being those named as the subjects of instruction in the oldest statutes of the University of Cambridge, A.D. 1396; and thirdly, a few of the more recent pioneer treatises which may be regarded as the precursors of our present-day text-books.

At the head of the first class stands one which, according to the adage just quoted, has earned sufficient value to be a worthy Royal gift. Its age is a little over the seven times seven times seventy years, as it was written in the days of Amenhetp III., about B.C. 1500. There are about a score of Egyptian medical papyri known, but this is much the largest, consisting of 107 pages, and it is also the oldest medical work extant. It was found in a tomb at El Assassif in ancient Thebes, and was purchased by the late Professor Ebers, for the Leipzig Museum. We turn to it with expectancy to ascertain what was the wisdom of the Egyptians in the art of medicine, but I fear we shall turn away from it with a sense of disappointment. It begins with a high-sounding preface, which, leaving out some repetitions, runs somewhat thus:

"Beginning of the book of preparing remedies for all parts of the body. I come from Anu, with the priests of Hetuat, of the Lord of healing, the King of eternity and protector. I come from Sais with the Mother Goddess who guards me. There is given from the Lord of All, the word to remove all deadly disease of all sorts. There are sections for the head, neck, arms, flesh, limbs, to remove the hurt done by the Ruler of those who have brought diseases on my flesh. . . . It is his guide Tehuti, who gave me this word. Whom the God loves he makes to live. I am one whom the God loves He makes me live."

Then follows a magical spell to be repeated when the remedies are being prepared. The main bulk of the treatise consists of prescriptions, 811 in number, for diseases of the different parts. Interspersed are short diagnostic aphorisms, about 62 in number, mostly about abdominal diseases and swellings, and there are over a score of magical spells. As a sample of the prescriptions we take one purgative, consisting of equal parts of *uam* seeds, *aneb* herb, *keseb't* fruit, honey, and *s'neft*. We have no means of knowing what these ingredients are, and cannot consequently ascertain their value. Where we can identify them they do not seem very active; thus, in the prescription on page 66, which professes to be the oldest—made by King Teta as a hair-oil for his mother Ses, about 1500 years B.C.—the ingredients are dogs' claws, an ass's hoof, and dates, all boiled and rubbed up together in oil. For blindness, take two pigs' eyes and the fluid belonging to them, eye powder, vermilion and honey equal parts, rub together, and put into the patient's ear, repeating this formula twice: "I have brought this thing and put it in its place; the crocodile is weak and powerless."

One sample of the aphorisms will suffice (page 25): "If ye see one with a swelling feeling like dough, his body is

hard under it; he is sick in his *ro-ab*. It is a swelling of his body that finds no way out and there is no passage for it out; it is corruption in his body. Nothing comes out. It is the *hesept* worm. If it be not the worm it feels like a ball. If it empties he gets well; purge him, and immediately he will get well." Now, *ro* means "mouth" and *ab* "heart," so *ro-ab* is the mouth of the heart; but the descriptions fit most closely with something abdominal, probably intestinal. Ebers guessed that it might be the cardiac orifice of the stomach, but that is purely hypothetical. The prescriptions profess to come from many quarters. One was composed by the Goddess Tefnut, for Ra, and consists of *āmāū* flour, *s'neft* fruit, and goose grease pounded together six times, and useful for all wounds and sickness. Another was invented by Seb, and a third by Isis.

On pages 99 and 100 there is a treatise on blood vessels, the book of the secrets of the heart; these vessels are to be traced by the finger from the heart. At one time I thought it might be possible to recognise some real anatomical knowledge in this section, but, on careful revision, the whole is so fanciful that no reconstruction of the author's vascular system can come any way near to reality. Four vessels go from the heart to the nose, of which two carry slime; four divide at the back of the neck to nourish the hair: four go to the two ears, the breath of life goes to the right ear, the breath of death to the left; six vessels go to the two arms, six to the legs, two go to both testes, four to the liver, bringing moisture and vapour; four go to the intestines, two to the bladder, and four to the anus. A later recension of the anatomy is given on page 103, which only gives two vessels each to the arm, to the leg, to the occiput, to the eyebrow, to the forehead, and to the nose.

The last section on page 103 claims to have been in existence in the days of Hesepti, who lived about B.C. 4000; similar claims to antiquity are found in the medical papyri of London and Berlin, which, though smaller, have a general resemblance to this. This short sketch will suffice to show that the Egyptian medicine at the beginning of the new empire was little else than folk-lore, empiricism, priestly tradition, and magic, with no underlying knowledge of the structure of the body and no unifying theory of disease, except the elementary notion of malign influences.

In later times the Greeks learned Egyptian empiricism and engrafted it on a basis of philosophy. The other later Egyptian papyri down to the Greek period show no advance on the knowledge represented by the Papyrus Ebers.

We pass over a thousand years and from Egypt to Greece, and we take as our representative work of Greek medical literature the writings ascribed to Hippocrates. My copy is the Aldine, the first printed edition produced at Venice in 1525. The Father of Medicine, born at Cos, lived most of his active life at Larissa, in Thessaly, and died there about B.C. 390. Of the fifty-six works here ascribed to him, only seven are certainly genuine—the book on air, water, and soil, two of the three books on epidemics, the prognostics, the prorrhetics, or predictions, the aphorisms and the diet of acute diseases; possibly the "wounds of the head" may be genuine. Six others were almost certainly written by Polybus (his disciple) two probably by Thessalus (his son), and the others by later writers of the Dogmatic School which he founded. The seventh genuine work is the oath which he exacted of his disciples, which is one of the most significant evidences showing what manner of man he was. It runs somewhat thus:—

"I swear by Apollo the Physician, by Asklepios, by his daughters Hygeia and Panacea, and by all the Gods and Goddesses, that to the best of my ability and judgement I will faithfully keep this oath and obligation. The master that has instructed me I will esteem as my parents, and shall supply as occasion may require with the comforts and necessaries of life. His children I will regard as my own brothers, and, if they desire to learn, I will instruct them in the same art without any reward. The precepts, the explanations, and whatsoever else belongs to the art I will communicate to my own children and to such other pupils as have subscribed to this oath, and to no others. My patients shall be treated by me to the best of my power and judgement in the best manner without injury or violence. Neither will I be prevailed upon by another to administer pernicious physic, nor will I be the author of such advice myself. I shall never recommend means to produce abortion, but will live and practise chastely and religiously. I will not meddle with lithotomy, leaving that to operators of that art. Whatever house I am called to attend I will aim at making the patient's good my chief aim, avoiding all injury, corruption, unchastity, and whatever I hear in the course of practice relating to the affairs of life that ought to remain secret nobody shall ever know from me. May I be prosperous, and honoured and esteemed by all men as I observe this solemn oath, and may the reverse be my lot if I violate it and forswear myself."

The works of Hippocrates would easily supply material for the whole time at our disposal, but they are accessible to you at any library in many editions in Greek, Latin, or English, and you will find them well worthy of perusal.

Along with Hippocrates as a pioneer we may bracket Theophrastus of Eresium, the first writer on materia medica. He was born about the date of Hippocrates's death, and became an active medical and philosophical teacher. He collected all the herbal lore of the day, and wrote this book on the history of plants, in which he described about 500 species, giving the medical properties of each. There is much of interest in it even yet, and it remained a classic authority on the subject down to the seventeenth century. His teleology and his reverence for the Great First Cause made his writing popular as long as education was controlled by the Church. My translation is the first Latin edition, printed and published at the famous press of Cratander of Basel, 1534. The translator, Theodore Gaza, was one of the most remarkable of the band of scholars who, after the dark ages, brought back the philosophy and culture of Greece to Europe in the early fifteenth century.

From Greece to Rome is a natural transition at the beginning of the Christian era. In the Golden Age of Latin literature medical writings are conspicuous by their absence. Cato and Pliny inveigh against those Greeks who practised the art in Rome, and reproached them for their evil practices. Among the earliest authors just at the beginning of the Silver Age, however, Cornelius Celsus takes a conspicuous position. His eight books *de re medica*, written probably in the time of Tiberius, in the first century, A.D., constitute a part of the classics of the science, and have always been popular for their pure, elegant, and luminous style. They are worthy to be read to-day, not only on this account but also because they fill up the historic gap between the Greek dogmatists and Galen. They give us a record of the growth of opinion in the Alexandrian school, and the rise and progress of the medical sects of Empirics and Methodists. The first printed edition was that issued at Basel in 1528. This small duodecimo edition was printed by Tornæsius at Lyons in 1549, and is a beautiful example of italic typography. To the anatomist Celsus is especially interesting, as he gathers up some of the current descriptions of parts from sources which have disappeared. Critics are divided on the question whether he was a practising physician or not, and there is much evidence, both internal and external, in support of the view that his interest in medicine was chiefly, if not entirely, literary and philosophical. Pliny mentions him as a general writer, but ignores him as a medical author, and although his surgical descriptions are graphic they might easily be those of an onlooker, not of a practitioner, and he never refers to any case which had been treated by himself. He wrote on rhetoric and other subjects, but these works are not extant. We, however, know so little of him personally that the question must remain an open one. He has often been confounded with his later namesake, the Epicurean Celsus of the time of Hadrian, whose attack on Christianity under the name "The true word" was so completely answered by Origen.

A century after Celsus another literary work appeared, this time in verse—the *De Medicina Praecepta Saluberrima* of Serenus Samonicus, who was put to death in the reign of Caracella, circa 206 B.C. This writer, in more or less elegant hexameters, gives us the treatment of diseases as then practised. Whether he was a practitioner or no we have not much evidence. Spartianus mentions the manner of his death, and from another source we learn that he was the tutor of Gordianus. The chief interest of this work is, that it was the precursor of a series of metric medical books. One well-known production of this description is extant, bearing the name of a little-known poet of the Golden Age—Aemilius Macer, a contemporary of Virgil; but it bears the marks of a much later authorship. It is called *De Virtutibus Herbarum*, and gives the medical properties of about eighty plants. The style is crude and the dogmata are essentially Galenical. It is in barbarous Leonine verse, and is probably a ninth-century production, by some attributed to a Frankish physician, Odobonus by name. Several editions are extant, the first being dated 1477. It was twice translated into English, one version being by Linacre in 1522. I show you here Tornæsius's edition of Serenus, 1549. A later edition, with a prodigiously bulky and dull commentary, was published by Humelberg in 1581.

I shall have occasion to refer to metric medical books later on, but may here note that such were not uncommon. The *Schola Salernitana* is the most famous of these, also in Leonine verse, written by John of Milan in 1099. Another and much later one, the *Sybilla Medica* of Carolus Sponius of Lyons, is a metric rendering of Hippocrates's *Aphorisms* and *Prognostics* in Latin verse, very eloquent and varying in metre, published in 1661. The same author reduced to verse a most prosaic subject, the origins and insertions of all the muscles of the body, under the title, *Musculorum Microcosmi origo et insertio*. He also varies the metre with the muscles in this book; thus he gives the sterno-mastoid in Sapphic stanzas with a versus Adonius every fourth line:

Mastoideus solet auspicari,
Munus e summi saliendo sterni
Limite et clavi media lacertus,
Pene bicorpor.
Inque processu incita mammiformi
Constituta ipsi fixit haereat cui
Firmita flexûs capitia patrare
Quoslibet aptus,

Phineas Fletcher's *Purple Island* (1633) may, perhaps, be put in this category as a metric treatment of a physiological subject, but it was scarcely intended for the medical student.

The second group of pioneer works to which I shall now refer are those named on the Cambridge Statutes of 1396, as limiting the medical curriculum of the period. All medical education at that time, as for the ten preceding centuries, was strictly Galenical, so these are chiefly some selections from the works of that great reformer of medicine and a few commentaries on them. Of Galen I need only remind you that he came from Pergamon, and settled in Rome about A.D. 160, and that his voluminous and very dull commentaries on Hippocrates and other treatises became in the third century the standard works on medicine. The parts of his works named in the Cambridge syllabus are four: Techne Iatrike, called in the barbarous Latin of the period the *Liber Thegni*. The edition of this that I show is that edited by Hieronymus de Salys of Faenza and Michael de Cappella, published at Venice in 1527. In this four separate Latin translations of the Greek text of Galen are printed side by side. [These are the ancient translations by Constantius Africanus: a second made from the Arabic version of Galen by Hali'ibn Rodoam, an Egyptian, in the twelfth century; a third by Nicolas Leonicetus in the fifteenth century; and a fourth by the ill-fated Laurentius Laurentianus, who drowned himself in 1515 when in pecuniary difficulties.] In this text the commentary of Hali'iba Rodoam, twice as long as the book itself, is included. This special commentary was not required, but the Cambridge course prescribes instead a brief introductory, the *Isagoge* of

Johannicius, properly called Honeinibn Ishak, a Christian physician from Hira in Babylonia, who died in prison in A.D. 873. This author's work is here translated into Latin by Hieronymus. It takes up five and a half pages, and is a most crabbed piece of contracted printing. The subjects dealt with in it are the elements, the humours of the body, the animal spirits, the colour of the hair—black from combustion, red from excessive blood, fair from absence of black bile, and grey from deficient natural heat. The eye is described as having seven coats, *rhetina*, *secundina*, *scliros*, *tela aranee*, *uvea*, *cornea*, and *conjunctiva*. The second Galenical book is the commentary on Hippocrates's *Aphorisms*, of which in this volume three translations are printed in parallel columns. The third and fourth are the *Prognostics* and the *De regimine acutorum*, which are given in this volume in Constantinus's translations. The translator was a remarkable man, a native of Carthage, who, after a life of many vicissitudes, became a Benedictine monk at Monte Cassino, and died in the convent of St. Agatha at Averso. Besides these, there are three small textbooks prescribed, not unlike our modern "cribs." Two of these were written by Theophilus, who was a protospatharius, or colonel of the guards, as well as chief physician, at the Court of the Byzantine Emperor Heraclius in the seventh century. The first he wrote, under the pseudonym Philaretus, on the subject of the pulse. Arteries are here described as receptacles for air, natural spirits, and a little blood. They began at the heart by a tube called by one translator *odorti*, by another *adhorta*. The method of feeling the pulse is carefully described, and its variations due to age, sex, season of the year, and locality are given. Ten pairs of varieties of pulse are mentioned—great and little, quick and gentle, vehement and languid, hard and soft, quick and slow, equal and unequal, regular and irregular, full and empty, deficient and intermitting, hot and cold. The other textbook is a longer work on the urine, published under his own name, Theophilus. According to him the urine is formed in the vena portae and brought to the kidneys by the vena cava; its colour, consistence, and sediments are described at length. I here show two versions of these, one by Hieronymus, in 1527; the other, in which urine is called *lotium*, by Albanus Torinius, Professor of Medicine at Basel, written at the beginning of the sixteenth century and printed at Basel by Petrus in 1533.

These works were intended to be learned by heart, but their very condensed form was found to be a difficulty by some. An English Benedictine monk in the twelfth century, John Giles by name, better known by his Latinized title, Johannes Aegidius, rendered both these works into Latin heroic verse. This was first printed by Wolfius of Basel, with a long commentary by Gentilis, of Foligno, in 1529, and is praised by its editor, Venantius Mutius of Camerino, as better than that of Philaretus, which in avoiding the Charybdis of confusion flies into the Scylla of brevity. As a specimen we may take the first few lines of the *De Urinis*, amusing for their notions of etymology:

> Dicitur Urina, quam fit in renibus una,
> Aut ab *Urith* Greco, quod demonstratio fertur,
> Aut quia quod tangit mordet desiccat et urit.

The last canto contains an attack on the school of Montpellier, the rival of the Salernitan to which Ægidius belonged, and especially on one Petrus Musandinus, whom he accuses of copying him. He also commemorates two authors on urine whose books are not extant, Urso and Maurus. This Giles is not to be confounded with the Portuguese Dominician of the same name. Some authors erroneously describe him as an Athenian.

Three other treatises are included in the Cambridge list. Two of these were written by Isaac Israelita Beimiram, a tenth-century physician. The larger one is on urine, and resembles that of Theophilus. In the edition which I show it is translated from an Arabic original, and is the subject of a long commentary by Petrus Hispanus. The smaller is a compendium of practice of medicine, which Constantinus, its translator, calls the *Viaticum*. Isaac was the adopted son of a certain Arabian King Solomon, and died A.D. 940. This edition of Isaac's works was edited by Andreas Turinus of Piscia, and printed at Lyons in 1515 at the famous press of Joannes de Platea. The *Viaticum* was translated from the Syriac and contains some good advice: for example, under the head, "De Ebrietate," he says: "Oportet vinum bibentes quantitatem vel qualitatem cavere que eos valeat inebriare." Of hair he says that it is produced by the vapour of hot humours, and when these vapours increase the hair grows, when they cease the hair falls out. As its translator says, it contains milk for sucklings, harder things for those with canine teeth.

The last work of the Cambridge list is on pharmacy, the *Antidotarium* of Nicolaus, Praepositus of Salernum written in the early part of the twelfth century. It was first printed by *Jensen* in 1471, but this edition is exceedingly rare; the copy I show is bound up with the works of the Arabian author Mesuë, and printed at Venice by Juntas, in 1549. It is a remarkable illustration of the polypharmacy of the Galenical School, and contains 140 formulæ, one of which was said to have been composed by Ezra, when returning from the Babylonish captivity. While on this book I may mention that the *Antidotarium* continued in use until 1540, when it was replaced by the first European pharmacopœia, that of Valerius Cordus of Nuremberg, which in this country gave way in 1618 to the first London *Pharmacopœia*. Looking over this book one feels how thankful the present-day student should be for his deliverence from such a text book. It contains 1,300 drugs, among which are puppies, earthworms, hedgehog, green frogs, sharks, moles, vipers, foxes, which must be killed by hunting and opened immediately. Human skull mummy powder, human fat, fæces, urine, sweat, and saliva, are all official, as also the dung of the dog, wolf, mouse, goat, and horse, pearls, amber, calcedony, lapis lazuli, and other precious stones. In one plaster live frogs are an ingredient. In the antidote of *Mathiolus* 142 ingredients are contained in varying quantities, and one singular compound is called the electuary of warm germs. This consists among other

ingredients of red rose petals, lavender, lign, aloes, liquorice, spodium, crocus, and mastich, white pearls, zedoary root, doronicum, lemon-peel, mace, bergamot, ambergris, red coral, amber, ebony shavings, sapphire, hyacinth stone, lard, garnet, emerald, cinnamom, zurembet, lichen root, cloves, ginger, long pepper, two forms of spica cardami, gold leaf, silver leaf, and musk, all to be powdered and mixed, and kept closely excluded from the air.

The humanist revival of the fourteenth and fifteenth centuries revolutionized the study of medicine. No longer trammelled by servility to Galen, researches were instituted in all branches of knowledge. The line between theory and practice becomes sharply defined in the textbooks, and the former, under the term *Institutiones Medicinae*, becomes the subject of numerous treatises; the latter, under the title "Consilia Medica: aut Consultationes" also develops a literature of its own. (The examples of these shown were Heurnius's *Institutiones Medicinae*, 1611, and his *Praxis Medicinae*, 1590). Then anatomy became developed as an independent subject, and separated from the institutes with treatises of its own. (The books shown were Vesalius, 1543; Remmilinus, 1619, and the first edition of Halle, and an early edition of Vicary as the pioneer English works). At first anatomy included physiology, but afterwards, when the discovery by Harvey of the circulation (1619-1628) had stirred up special and experimental interest in functions, this branch likewise became isolated, Haller's *Primeae Linae Physiologiae*, published at Göttingen in 1747, being the pioneer students' manual. Pathology, at first part of the institutes, became the subject of special treatment in the seventeenth century, the first English book under this title being Charleton's *Exercitationes Pathologicae*, but the most important of the earlier treatises was Morgagni's great folio, *de sedibus et causis morborum*. The microscope was used first in human anatomy by Malpighi, of whose work describing blood corpuscles, Malpighian tufts, and the Malpighian bodies in the spleen. The edition shown was published in London in 1669. Hooke's *Micrographia* soon followed, the parent of our handbooks on histology. Thus by the middle of the eighteenth century the student had to hand books on anatomy, physiology, materia medica (not yet chemistry and physics), pathology, systematic therapeutics, nosology and clinical medicine. (As a specimen of the first English treatise on midwifery, Reynold's *Woman's Booke* was shown). The literature of surgery, at first in classic times inseparable from medicine, appears in the mediaeval times independent. Salicet, Lanfranc, but especially Guy de Chauliac, who wrote in 1363 in the days of Clement VI, were its principal authors. (The exceedingly rare Venice edition, 1490, edited by Thura de Castello, was shown). His seven sections are on anatomy, on tumours, on wounds, on the algebra and extension and restoration of fractures and dislocations, on surgical sicknesses such as gutta and skin diseases, baldness, ophthalmia, and affections of the nose and mouth, and on antidotes. If his book may be taken as parent of the treatises on the theory of surgery, that of Scultetus deserves to be reckoned as parent of the work on practical surgery. His gruesome pictures have seldom been equalled and never surpassed. Scultetus published his book about 1640. The edition I show is the Dutch edition, with additions of 1693.

The sixteenth to the eighteenth centuries were marvellously prolific in medical books. There were no journals to be safety-valves for the professional *cacoëthes scribendi*, so every man who thought he had a message for his time produced a book. Most, of course, are worthless, the same statements dished up again and again, but grains of wheat can be gleaned here and there in the mountains of chaff; out of these were evolved the text-books you have now in use, and the development from the eighteenth to the twentieth century is marvellous. They are not yet perfect. When our knowledge is such that from a complete series of general laws, founded on a solid basis of induction, all details can be directly deduced, then will come the millenium of medical literature, but that is a long way off yet.

A vote of thanks to Professor Macalister was proposed by Mr. F. W. Palmer, seconded by Mr. Mollison, and carried unanimously by the society.

The President of the Society, Sir Samuel Wilks, who was greeted with the greatest possible enthusiasm by all present, spoke as follows:—I am not too weak or wanting in perception to be unaware of the fact that I am one of the objects of attraction this evening and therefore, although you have had a very good discourse from Professor Macalister, I shall devote the small time at my disposal to speak of myself. Indeed, I might drop my personality and talk of myself as the patient, styling my short story a clinical lecture on an interesting case, for a good case it is, seeing the patient stand before you, almost as a resurrection, at the same time a living example of the learning and great skill and judgment of the men of Guy's.

I was, as you know, an example of the disease which of late has been known by that dreadful name "appendicitis." You are aware that Addison published a very perfect account of it in his lectures for 1836, and herein, although he stated that disease of the appendix was the most frequent cause of abscess in the region of the cæcum, it was by no means the only cause, and therefore he gave the name of typhlitis or perityphlitis to the inflammation and suppuration which so frequently occurred in the right iliac region. These were by far the better terms, for they are clinical, the only ones which should ever be used in the nomenclature of disease; pathological terms are bad as they imply finality and truths which have not yet been reached. Typhlitis was therefore the correct term to use, as was done in the case of His Majesty the King.

This is the disease from which I suffered. I never suspected its existence and therefore in no way assisted my doctors in the diagnosis of my malady. It was only a day or two before the operation that there was any local pain or swelling to indicate its nature, and then it

became evident that there was only one thing to be done. Mr. Brydone gave me the anæsthetic and directed me to look first to the right and then to the left, and very soon after I sank into forgetfulness. A large calculus was found and the appendix sloughing or almost gangrenous. I don't know whether any light has been thrown on the nature of the disease, whether indeed there must be a nucleus to determine the formation of the concretion, or whether it be a mineralization of the waxlike secretion which is so often found in this little tube. In my case the sloughing state of the bowel caused my attendants much anxiety, and for two or three days my fate was in the balance, when very remarkably, considering my age, a healing process commenced and the turn went in my favour. Many friends at this time wrote and congratulated me on my recovery but the worst was to come. Symptoms of septic poisoning set in and lasted some weeks, so that I grew daily worse and my life was despaired of. This part of my illness I have thought much over and what was its nature. It may appear that any opinion of mine, the subject of it, can be of little value compared with that formed by those who stood by me and could observe unbiassed the symptoms for themselves, and more especially this must be the case when I was so often delirious and was unconscious of all that was going on around me. The only thing to be said on the subjective side is that the patient knows how he suffers and must be better aware of the seat of his pain and troubles. I could not but know that the whole of the mucous membrane of my alimentary canal was affected, or in common parlance acutely inflamed, my tongue and throat were intensely red, and the epithelium being gone, everything which was not of the blandest description made it smart, so the very finest champagne and Bordeaux wine scalded me; all swallowing was painful, and when the food reached the stomach the direst gastralgia or heartburn came on, most of the fluids which I took returned, and this with the diarrhœa and paralysis of the bowel completed my trouble.

As in the exanthemata and many other forms of blood poisoning the effect is shown more markedly on the mucous membranes within and the skin without (scarlatina for example), so my skin became dry and papular, and on the legs the rash was eczematous. Little food was taken, and this being not assimilated I wasted away until all my bones could be seen, and the end seemed then rapidly approaching. Of course, the very best treatment in the way of nourishment and medicine was given, but that which impressed me most and is still on my memory, is the day when I told my best friend, Mr. Symonds, that the thing which relieved me most and which I was allowed to take, was the alkaline lozenges made by Dr. William Roberts, composed, I think, of soda and calcium. He said he had wished to wash my stomach out but feared I could not stand the process. He thought, however, I could swallow the fluid and then reject it, so he put a large quantity of bicarbonate of soda in a tumbler of water and made me drink it, the pleasantest drink I may say I had had for a long time. He then requested me to bring it up again, and after that to repeat the dose and again reject it. I mention this because, judging from my own feelings, it was the only drug which relieved me. Then, again, I must mention how, when I was at death's door, he injected on two occasions a pint of water through the skin.

Well, I wonderfully recovered, as you see for yourselves, and remembering that all morbid processes run a definite course, and that in all probability living organisms of the bacterial kind have a life-history of their own, I have been considering whether something of this kind did not occur in my case.

I remember asking the late Dr. Cobbold, who was a great authority on parasites, what was the natural duration of life of a lumbricus or hydatid, and he could not tell me. But we do know that the commencement and termination of the exanthematous diseases are of a most definite kind, and I should say the same of diphtheria and many other specific diseases, and therefore the germs must have a life history. In the case of typhoid I do not know of any man of experience who would declare his capability of curing it, that is of arresting its progress. He is well content if he has conducted his patient through the disease, for it is often entirely due to him and his judgment that recovery has taken place. I cannot therefore but surmise that there might have been a natural ending in my case, and just as in typhoid we generally look to a duration of three or four weeks, so probably many forms of bacterial and septic poisoning may have their own distinct natural history.

As nearly the whole of the subject of bacteriology has developed since I left the hospital I have little knowledge of it, but as a mere surmise I have thought that I was affected by some intestinal microbe. I know that the intestine always contains numbers of these bodies and have thought whether any of these being taken up into the blood might have poisoned it; whether indeed the ordinary saprophytes might have done it. I believe, however, that I have read of more specific forms which have constituted in one case the deleterious matter in the autumnal diarrhœa of children, and in another a peculiar intestinal bacillus as the cause of dysentery. May there not be a peculiar kind in the appendix or cæcum which, entering the blood, should grow and spread through the whole of its most natural habitat, the mucous membrane of the alimentary canal? Although you speak of streptococcus and staphylococcus there may be allied genera, but more no doubt has to be learned, for I saw amongst the various papers discussed at the meeting of the British Medical the name of a Dr. Tchauduin, of Trieste, who had shown how some of the parasites associated with the ague gnat, the Ausphele, had shown different features in different subjects according to their time of development. So that, as special poisons of an organic nature and belonging mostly to the bacterial class, produce their own special symptoms as they have an affinity for one structure or

another, so it appeared to me that I was suffering from a blood poisoning, caused in all probability by bacteria whose essential seat and domain of growth was the alimentary mucous membrane.

When I arose from my bed I was unable to stand, so wasted and weak my muscular system had become, but when my limbs had recovered their strength I had still a great difficulty in walking upstairs and rising from my chair. In thinking this over I considered it most probable that the muscular tissues of the abdominal walls had been implicated in the amount of peritonitis which had existed. I was much interested in this question when I was leaving the post-mortem room here. You know that in pericarditis and endocarditis the muscular tissue of the heart may be involved, causing dilatation and the fibroid degeneration which you sometimes accidentally meet with. In pleurisy also of the lower part of the chest I have seen the muscular tissue of the diaphragm quite destroyed, so that it was one of the causes of shortness of breath. I mention this as having occupied my thoughts during my convalescence. In saying this I can imagine some of you remarking to yourselves that the ruling passion, pathology, still possessed me, you may perhaps be right.

A hearty vote of thanks to the chairman closed the evening.

Sport.

FOOTBALL FIXTURES.

Saturday, October 22nd.

G.H.R.F.C., I., v. Rosslyn Park, away.
II., v. Norwood, away.
III., v. Ealing II., away.
G.H.A.F.C., I., v. Weybridge, away.
II., v. Old Westminsters "A," home.

Saturday, October 29th.

G.H.R.F.C., III., v. S.E.A. College, away.
G.H.A.F.C., I., v. Reigate Priory, away.
II., v. Old Citizens "A," home.

Saturday, November 5th.

G.H.R.F.C., I., v. Rosslyn Park, home.
II., v. African Banks, away.
III., v. Kensington III., away.
G.H.A.F.C., I., v. Ewell, home.
II., v. Ewell II., away.

Rugby Football.

GUY'S 3rd XV. v. HARLIQUINS 3rd XV.

Played at Cricklewood on Saturday, October 8th, ending in a draw, 2 goals each. Wight and Harvey obtained tries for Guy's, and Kidd converted both. Lacey played a good game at back. Team:—

Guy's.—G. E. Lacey (back); H. F. Wight, J. N. Watson, A. Browning and C. H. Marshall (three-quarters); P. J. Monaghan and T. R. Harvey (halves); W. S. Kidd, H. N. Eccles, L. Milton, C. E. Lloyd, M. M. Adams, H. J. Clarke, Peall and Edsell (forwards).

GUY'S 3rd XV. v. DULWICH COLLEGE 2nd XV.

Played at Dulwich on Wednesday, October 12th. Guy's won easily by 3 goals 5 tries to 1 goal. Tries were obtained by Thompson (2), Bennet (2), Watson, Monaghan, Alcock and Harvey (1 each). Alcock converted two and Kidd one. Team:—

Guy's.—W. P. Vicary (back); R. S. Bennet, L. T. Baker, J. N. Watson and H. B. Palmer (three-quarters); P. J. Monaghan and T. R. Harvey (halves); A. Alcock, A. R. Thompson, R. Davies-Colley, L. L. C. Reynolds, D. Reynolds, W. S. Kidd, E. L. Elliott and D. Stout (forwards).

Association Football.

GUY'S v. NORMANHURST DRUIDS.

This match was played at Willesden on Saturday, October 8th, and resulted in an easy win for the hospital by 6 goals to nil. Guy's won the toss and kicked off with the wind. Our forwards took the ball at once into our opponents' half and Barber, receiving the ball from our left, scored with a long shot. Shortly afterwards Barnett added another from a fine centre by Wragg. From this until half-time we had all the best of the game, and further goals were added by Barber and Barnett.

On re-starting, we were compelled to act on the defensive for some time, but on settling down, we managed to keep the ball mainly round their goal. Barber, after dribbling through their defence, scored his third goal, and shortly before the end Litchfield added another. Team:—

Guy's.—E. A. Collins (goal): A. G. Jones, E. N. Plummer (backs); P. G. V. Pedrick, A. F. W. Denning and A. Zorab (halves); E. Wragg, P. C. Litchfield, H. Barber, D. J. Wearing and E. Barnett (forwards).

Remarks.—The team played well together and put plenty of dash into it. Both backs put in some good tackling and kicked well. The forwards combined nicely, considering it was the first match. Of the halves, Pedrick was the best, always feeding his forwards well.

GUY'S 2nd XI. v. NEW BECKENHAM.

This match, the first of the season, was played at Honor Oak on October 8th. Guy's were without the services of Crofts, who was unable to play. Guy's, playing with the wind, scored four goals during the first half. Four more were added in the second half. Our opponents failed to score, and a one-sided game resulted in an easy win for Guy's by 8 goals to nil. Goals were scored by Witts (4), Hinde (2), and Sims (2). The for-

wards combined well, Hinde and Witts being the most noticeable. Luhn fed the right wing well. As the score would indicate, the backs and goal had very little to do. Team :—

Guy's.—G. E. Rice (goal); H. R. Bastard, J. L. Jones (backs): —. Luhn, C. M. Plumptre, H. P. Aubrey (half-backs); C. Witts, H. Sims, —. Hinde, —. Mitchell, T Evans (forwards).

GUY'S 2ND XI. v. WESTMINSTER SCHOOL.

This match was played on the ground of the latter, in fine weather, on October 15th. Crofts and Wilts were unable to turn out for Guy's, the latter being on the injured list. The Guy's forwards were not to be denied for any length of time, and Barnett opened the scoring. In a very short time Guy's had increased their lead, Hinde cleverly directing a centre from Jones into the net. Barnett and Sims also scored before the interval. Three more goals by Barnett (2) and Hinde were added in the second half. Westminster were unable to score, Guy's winning an easy victory by 7 goals to nil.

The forwards did not show the combination of the previous Saturday, Barnett being the best. The half-backs were rather slow, this being probably due to the one-sided character of the game. The backs and goal had not much to do. Team :—

Guy's.—G. E. Rice (goal); H. R Bastard, C. W. Greene (backs); W. Johnson, —. Luhn, H. P. Aubrey (half-backs); J. L. Jones, H. Sims, —. Hinde, E. Barnett, —. Mitchell (forwards).

United Hospitals Hare and Hounds.

The annual general meeting of the above Club was held at Guy's Hospital on Thursday, October 13th, 1904, Mr. R. Rankine, in the unavoidable absence of L. A. Dunn, Esq., F.R.C.S., being in the chair.

The report for the past season showed that although not a single match had been won, yet there had been several notable individual successes—Hospital men filling the second place v. Thames H. & H., the same place v. Ranelagh Harriers, the first and second places v. Wellington College, and the first and third places v. Oxford University H. & H., who were, however, running a weak team.

The Club's prospects for next season are exceedingly bright. It is hoped that the London Hospital, stimulated by the arrival of R. McC. Linnell of the C.U.A.C., will enter a team for the cup, now in the possession of Bart.'s, who last year beat the holders (Guy's) by one point only.

A vote of deepest sympathy was passed with O. S. Norton, the retiring captain, in his recent sad bereavement.

It was decided to meet the following clubs:—Oxford U.H.&H., Cambridge U.H.&H., Thames H.&H., Blackheath Harriers, South London Harriers, Wellington and Laveing Colleges, and to hold the Inter-Hospital Cup Race at the end of February.

The Gold Medal for this race last year was won by A. L. Candler (Bart.'s who finished first), and the Silver Medals for the second and third places by T. E. A. Carr (Guy's), and W. B. Grandage (C.U.A.C. and Bart.'s) respectively.

A vote of thanks to the past secretary for his exceedingly valuable services to the club, and to the chairman, terminated the meeting.

The following officials were elected:—President: H. A. Munro, Esq., M.B., B.Ch. Vice-Presidents: P. Furnival, Esq., F.R.C.S., L. A. Dunn, Esq., F.R.C.S., H. Morley-Fletcher, Esq., M.D., T. G. Stevens, Esq., F.R.C.S. Captain: T. E. A. Carr (Guy's). Hon. Sec. and Treasurer: H. Stott (Guy's). Committee: O. S. Norton (Westminster), A. L. Candler (St. Bart.'s) G. L. Birt (Royal Dental), V. Townrow (Guy's), F. Standish (London).

Calendar.

October, 1904.

Sat. 22.—Messrs. Golding-Bird and Dunn's take-in; Drs., M. Leckie and F. A. Sharpe; Cl., M. J. Mottram.
Physical Society's meeting at 8 p.m. Clinical evening. President: G. Russell, M.B.

Thur. 27.—Mr Jacobson and Sir Alfred Fripp's take-in; Drs., H. A. Watney and A. G. Jones; Cl., G. C. F. Robinson.
G.H.C.U., Address by the Rev. W. R. Mowll, M.A.

November.

Sat. 5.—Physical Society's meeting at 8 p.m. Pathological meeting. President: N. I. Spriggs, M.B., B.S.

Reviews.

The price of books submitted for review should in every case be stated.

Serums, Vaccines, and Toxines, in Treatment and Diagnosis. By Wm. Cecil Bosanquet, M.D., Oxon. p.p. 344. (Messrs. Cassell & Co.). 7s. 6d.

This is the first volume of a series of text-books on modern treatment, which, if they maintain the high standard reached by this work, should prove most invaluable. Pleasantly written, and well-bound in a limp cover, which just fits the pocket, it is a book which no medical man should be without, if he has the least desire to be up-to-date.

The very latest literature, both foreign and English, has been ransacked, and we are here presented with an excellent abstract thereof; not alone, but accompanied with a just and critical estimate of each man's work, and

the relative value of the results accomplished. Of course each chapter starts with a short account of the micro-organism considered responsible for the disease, but the uninteresting details, as to which medium it grows best on, etc , are not dilated upon; we are, however, given full accounts of all the serums, antitoxic, and antibacterial, which has been devised to counteract its effects ; and the author's conclusions are drawn up in tabular form at the end of each chapter, making reference particularly easy. We are told that the serum of thyroidectomised animals have been used successfully in the treatment of Graves' disease, expense being its principal drawback. Hay fever during the last twelve months has also been treated with serum derived from animals injected with the pollen supposed to be responsible for the disease. A description is given of the attempts made to combat cancer by serum, both Coley's fluid and others: and there is a very good and fair account of the value of tuberculin and tuberculoidin.

We have never seen such a clear explanation of Ehrlich's theory of immunity, or such a good analysis of the statistics of diphtheria: a very striking fact being that in six years, at the Brook Hospital, there was not a single death among those cases treated with serum on the first day of the disease. Diphtheria antitoxin apparently has no effect on the subsequent paralysis, so that its introduction, as it has saved so many severe cases that otherwise would have died, has increased the percentage of cases that are followed by neuritis. The advantages of antityphoid inoculation are strikingly shown by the statistics of its use with our army in South Africa, the death rate in each case being considerably less, though the case mortality seems to be unaffected, so that it differs from vaccination, in that, though an inoculated man is less likely to get typhoid, if he does get it, his previous inoculation will not lesson the severity of the attack. An admirable book that we can most thoroughly recommend.

Atlas of Human Anatomy, By Carl Toldt. Translated by Eden Paul: 5th Section. Angeiology. 190 figures and index. (Messrs. Rebman, Ltd.). 13s. 6d. net.

The practice of learning anatomy by means of figures and diagrams is universal, as a glance into any dissecting room will prove. Such is the *raison d'être* of the book before us. We have already noticed the previous sections of this work in our columns, and the present volume maintains the high standard of excellence reached by its predecessors. The heart always was a "thing of joy" for the anatomical artist, as it provided him with a series of pictures, in which he could be lavish with his colours, his blues and his reds. The figures are well printed and very distinct, though we think those on the lymphatics of the body might be clearer and fuller. As might be expected, the lymphatics are always more studied by surgeons than by anatomists, and are accordingly always better described in the former's books. The microscopical sections of veins and arteries are poor, but we particularly like the arrangement of the myocardium, and the figures illustrating the development of the circulation. An appendix contains the various differences between English and German terminology, while each name throughout the book is given in both English and Latin. This work is probably the best of its kind that has ever been published, and is well worth obtaining by those who can afford such a luxury.

Appointments.

Civil.

Attwood, R. D., L.R.C.P. Lond., M.R.C.S., has been appointed Resident Assistant Medical Officer of the Southwark Union Infirmary.

Balderston, Robert, M.B., M.R.C.S., L.R.C.P., has been appointed Honorary Assistant Physician to the Home and Infirmary for Sick Children, Sydenham, S.E.

Beattie, F. A., L.S.A., has been appointed Medical Officer of Health, Haylandswaine Urban District.

Papers by Guy's Men.

The Treatment of Malarial Fever by Injections of Quinine. By Captain C. M. Fleury, R.A.M.C.—*Journal of the Royal Army Medical Corps* for October.

Birth.

RICHMOND.—On September 26th, at 28, Lower Road, S.E., the wife of B. A. Richmond, M.B., B.S. Lond., of a son.

Marriages.

ATKINS—SMITH.—On September 29th, John Atkins, M.B., F.R.C.S., to Elizabeth May, daughter of J. D. Smith, of Halesworth Road, S.E.

COLLIS—GURNEY.—On October 6th, at All Saints, Gosforth, by the Rev. Dean Kitchin, D.D., assisted by the Rev. W. M. Davidson, M.A., Arthur J. Collis, M.A., M.D. Cantab., third son of W. Blow Collis, of Swinford House, Stourbridge, to Dorothy Mary Wren, fifth daughter of the late Rev. H. Palin Gurney, D.C.L., and Mrs. Gurney, of Roseforth, Gosforth, Newcastle-on-Tyne.

FOTHERBY—BARRETT.—On the 5th October, at St. John the Baptist's, Kensington, Henry A. Fotherby, L.R.C.P., M.R.C.S., of Headcorn, Kent, to Jane (Bee), eldest daughter of Dr. A. E. Barrett, of Holland Park Avenue, and grand-daughter of the late Hon. Thomas R. Keppell.

Deaths.

BOSSEY.—On September 27th, at Mayfield, Redhill, Francis Bossey, M.D., aged 95 years.

PHILLIPS.—On October 12th, at De Courcy Lodge, Southsea, after a week's illness, Ernest William Phillips, M.R.C.S., L.R.C.P. Eng., aged 43 years.

Ed.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 430.] NOVEMBER 5, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Death of Mr. Lushington	453–454
Passim	454–457
Pupils' Physical Society	457
A Case of Enlarged Liver and Glands with Purpura and Fatal Hæmatemesis. ? Sarcoma. Clinical lecture by Dr. Fawcett	457–462
The Life-work of an 18th Century Man-Midwife	462–464
The Examination of a Chylous Ascitic Fluid	464–466
Notice	466
In Lighter Vein	467
Papers by Guy's Men	467
The late Doveton Martin	468
Guy's Physiological Society	468
Correspondence	469
Appointments	469
Guy's Hospital Dental Society	469
Reviews	470–471
Pass List	471
Sport	471–472
Change of Address	472

Death of Mr. Lushington.

BY the death of Mr. Lushington, in his 83rd year, who passed away on the 29th ult., at his country house at Cobham, there is removed a well-known personality in the modern history of Guy's.

The eldest son of the late Rt. Hon. Stephen Lushington, Dean of the Court of Arches, Mr. Lushington, in early life, entered the Bengal Civil Service, rising steadily to the position of Financial Secretary to the Indian Government. After thirty years in India, Mr. Lushington returned home, and in the year 1873 was elected a Governor of the Hospital in the room of his father who had then recently died at the great age of 97. Upon the resignation by Mr. Turner of the post of Treasurer of the Hospital in May, 1876, Mr. Lushington was chosen to fill that office, which he occupied for the next twenty years, retiring in November, 1896. The old system of the nursing arrangements of this and, indeed, all other hospitals, was, about the time of his appointment, on its last legs, and Mr. Lushington with much energy set about the reorganisation of that important department. That this was not done without friction and disturbance is a matter of hospital history, but it is not worth while at this date to reopen a grievance felt acutely at the time, when the result has been the system of high-class and trained nursing now obtaining in the wards to the comfort of the patients and the well-being of all concerned.

Shortly after his acceptance of office, viz., in 1879, the earlier effect of agricultural depression throughout the country was beginning to make itself felt, and disastrous times fell upon the Hospital's country estates. With great pluck and energy the newly-elected Treasurer faced the loss of Hospital revenue (some £20,000 a year), and an Appeal for assistance resulted in his obtaining large support from the Governors, Staff, and the public generally, an amount of about £140,000 being then secured for the Institution. This sum, large as it was, only tided the Hospital over a period of about fifteen years, when it again became necessary to place its financial position before the benevolent.

The establishment of the Re-endowment and Sustentation Funds was then inaugurated by Mr. Lushington, with what result most of our readers are fully aware. One of the last acts of his treasurership was to invoke and to receive the influential aid of the late Mr. Gladstone as a Governor in the foundation of the Sustentation Fund, for it is not too much to suppose that, but for the highly important letter from that Statesman published in the *Times* in October, 1895, the Fund would hardly have reached the

proportions it finally assumed. Indeed, it is no secret, we believe, that it was in consequence of this letter that His Majesty, then Prince of Wales, decided to throw himself into the scheme for the Re-endowment of the Hospital, which met with so large a measure of success.

During his term of office the land was secured upon which the College now stands, and it was in his treasurership that the Dental School was founded and sent forward on a successful career, and the establishment also secured, upon a sound basis, of the Laundry Hostel. In all these works he had the powerful assistance of the President of that day, viz., the present Lord Aldenham, who has thus survived a colleague with whom he worked for the good of the Hospital for a period of twenty years.

Like many Anglo-Indians, he was autocratic at times in demeanour, and held his own position with firmness, but those who were most in touch with him were able to recognise beneath the surface much kindness of heart and a keen desire to help and assist in the upholding of the great traditions of the Institution with which he was so long connected.

Passim.

THE arrangements for the Residents' Dance proceed merrily, and this year's function bids fair to be as great a success as its predecessor, with the Court Room—that happy hunting-ground of the Christmas Resident—groaning again under the weight of relaxed dignity. Those who have not yet secured tickets are counselled to do so before it is too late.

WE deeply regret that in our last issue we should have been guilty of a misstatement. The Oxford and Cambridge Dinner will not be held at the Bridge House Hotel, but at the Holborn Restaurant. Our deepest apologies to all concerned.

AN excellent move has been made on the part of certain of the Residents, and a new batch of Contemporaries, to be named the Centurions, is in process of formation. These will constitute the bulk of the senior men at present at Guy's, and like their brethren before them (and unfortunately some time before them) it is their fixed intention to dine together once a year for so long as they shall be in the land of the living. The idea of the Contemporaries' Club is a most excellent one and must appeal to all ordinarily constituted Guy's men. If there be any man who is inclined to neglect such an opportunity, we would earnestly beg of him to be wise in time. It is safe to say that in years to come, whatever dinners he may attend in the course of the year (and heaven send they may be many and sumptuous), there will be no dinner quite like the one at which he will meet the old friends of his student days. The full particulars of the scheme are in the hands of the printer and will soon be circulating, so that we need not indulge in details. The thanks of all those concerned are due to the originators of the scheme.

MANY Guy's men will remember Burnett Ham, who qualified in 1896 after an eventful career at Guy's, during which he succeeded in carrying off many prizes and medals. Perhaps one of his chief claims to distinction (may we be forgiven for saying so) is the fact that he was one of that immortal group that was the *fons et origo* of the *Guyoscope*. We believe we are right in saying that Ham was the first editor of that irrepressible journal. To the philosophic mind there is no great gulf between editing the *Guyoscope* and making a special study of Public Health; in fact, the two are very closely associated, and we are accordingly not surprised to find that Public Health is Burnett Ham's especial forte. As Medical Officer of Health for Brisbane, Dr. Ham is at present falling foul of the South Brisbane aldermen, who are bent on obstructing certain necessary measures of sanitary reform. There

has been a slight outbreak of plague in the city that has been definitely traced to unsanitary buildings which it is Dr. Ham's wish to see demolished. The South Brisbane aldermen, however, are of a different mind, and the struggle is still very bitter; so hopeless, indeed, has it seemed to Dr. Ham, that he has been sorely tempted to resign his post, leaving the unclean aldermen to stew in their own juice. Happily for South Brisbane, however, he has thought better of this, and we are sure that all Guy's men, and in particular Dr. Ham's especial friends, will join in a message of congratulation and encouragement, wishing him a speedy and decisive victory over his opponents.

HEARTY congratulations to Mr. H. T. Hicks, whose wedding was celebrated on Monday last (October 31st) at Holy Trinity Church, Sloane Street.

IN the *Morning post* of November 1st, a long letter appeared from Mr. Stephen Coleridge to Mr. Hugh C. Smith, the Chairman of the Council of King Edward's Hospital Fund, containing allegations of the very gravest nature against the various metropolitan hospitals. Mr. Coleridge accuses the financial managers of these hospitals of misappropriation of the loans granted to them by the Council of the Fund. The letter concludes thus:—

> I believe the time is now not far distant when it will be universally recognised that these misappropriations constitute one of the most serious scandals of our time, jeopardising the continued independent management of our hospitals, and very grievously injuring the sacred interests of the sick poor. The duty laid on me as the person entrusted by a great society with the task of defending helpless animals from torture, has led me incidentally to the discovery that one wrong has inextricably been interwoven with another, and I have found that where animals are vivisected under the patronage of the hospitals there it is that the poor are robbed of what is theirs by every law of probity and every precept of honour. I deeply regret that so far I have been left to enter my protests alone, and that not one of the great and eminent persons that form the council of the King's Fund has found himself able to say a word in public against the detestable practice of vivisection, and only one has been found to raise his voice in protest against these indefensible financial transactions.

This may pass muster amongst ignorant and bigoted fanatics, but fortunately the committee appointed to investigate the matter by the Council of the Fund are pre-eminently sane men, and the case for the hospitals will be stated before them by witnesses whose words will carry more weight than does the libellous stuff that we are accustomed to hearing from the Secretary of the Antivivisection Society.

WE have no wish to appear officious or to show in any way indecent disregard for the subtleties of the secretarial mind, but at the same time may we venture the mildest of protests? The Debating Society shows no signs of life at present, and we are now nearly half-way through the Christmas term. We have no doubt, that, when the Society does eventually meet once more in the Smoking-room, we shall enjoy another of those intellectual treats to which we have become accustomed. At present as a body corporate our intellects stagnate. All freshmen should eagerly scan the notice boards for the blood-red sign of debate which will shortly, we hope, make its appearance. The Society relies for its existence upon new speakers, and, as it has never been disappointed yet, it behoves all freshmen blessed with ideas of any kind, however absurd, to look to it that they attend and take part in the debates.

The Pharmaceutical Journal of October 29th contains an interesting article on the Chemist in Gibraltar and Malta, and speaks of the testimonials from grateful patients which are to be seen freely plastered over the windows of the chemists' shops. The majority of these testimonials having been written in Spanish, the proprietor is obliged to exhibit translations alongside of them, and owing to his imperfect

acquaintance with our tongue, the result is sometimes a little curious. The following are examples of what is frequently met with :—

No. 1.

FROM HIGH-CLASS SPANISH GENTLEMAN.

Don Miguel Ferrara, Los Angeles, Calle Real, was recently seized with utterly damnable pains and aches in unmentionable parts of his vile body. After, however, consuming four (large size) boxes of Senor Porales' Patent Pills he was quite cured. Special notice.—This is altogether genuine.

No. 2.

FROM SMART-SET LADY.

Estimable Sir,

Last month, when suffering from horrid swellings (occasioned by fierce mosquito bites), I resumed my normal proportions by using your distinguished ointment. Since then I have only been stung by gnats.

DONNA MARIA TERESA ALBANESI.

The article goes on to say "Side by side with these Spanish tributes may occasionally be found others emanating from English customers. These are always regarded as a sure "draw," although they do not invariably merit this. The fact is, the writers sometimes take advantage of the dealer's want of intimacy with the niceities of British idiom. Thus, one may see such 'testimonials' as the following" :—

No. 3.

FROM NOTABLE ENGLISH POT.

Sir,

A week ago I had a bad attack of gout. From reading the advertisement in the *Gibraltar Chronicle* of your patent "Cure-all Specific," I have, however, felt so much better that I shall not require any medicine.

Yours faithfully,

JOHN BLAZER, D.S.O.,

Lieut.-Colonel King's Own Sharpshooters.

"The rank-and-file naturally follow the example of their superiors."

No. 4.

FROM HONOURABLE CORPORAL (BRITISH INFANTRY REGT.).

To Mr. Porales, Sir,

Having a big head the other day, owing to the rotten bad beer sold in the Sharpshooters' canteen, I drank a bottle of your saline mixture. Since then I have been let off all route-marching.

Yours gratefully,

JAMES BROWN,

Corporal, Fiftieth Fusiliers.

P.S.—You ought to send our sergeant-major a cask.

PERHAPS it is a sheer waste of time to seriously consider any of the vagaries of Mr. George Bernard Shaw, but certainly a remark made by "Keegan" in "John Bull's Other Island," now being performed at the Court Theatre, is about as inexplicable as any remark made by any of Mr. Shaw's characters in any of his plays. We should think that "Keegan," in the flesh, would probably be a man after G. B. S.'s own heart, in fact we suspect G. B. S. of masquerading once more before the British Public (leavened for the nonce by a goodly sprinkling of adoring Fabians) in the guise of the not-really-mad-but-only-brilliant Keegan. This latter, in bemoaning the contemplated arrival of the capitalist with his hotel, golf-links, and light railway, in the midst of hitherto peaceful Irish scenery, incidentally and contemptuously scoffs at the "operations for cancer and appendicitis" that follow in the train of civilisation. What such a remark as this may mean we are entirely at a loss to understand, and we doubt if the most fervid Shawite could explain it. Of course Mr. Shaw is an anti-vivisectionist, so one expects something extraordinarily foolish, but not sheer drivel, at least, not as a rule.

IT would be as well to call special attention to the Surrey and Middlesex match that will be played at the Honor Oak Park ground on Wednesday, November 9th. This is the first match of its kind that has been played on the Guy's ground, and it is hoped that Guy's men will make a special effort to be present. The stand will be completed, it is hoped, in time for the Rosslyn Park match to-day (November 5th,) and the stand money on November 9th will be handed over to the Clubs' Union together with a proportion of the total gate-money. Seeing that these innovations at Honor Oak have been brought about with a view of helping the Clubs' Union financiers in a very uphill fight, all Guy's men should heartily co-operate with these latter that this end may be achieved, and this they can do

Before the "Incisio!"

by turning up to watch matches and taking up their positions in the new stand. As regards our own team, we are told that there are those who are inclined to throw in their lot with outside teams. There never have been, and there never can be, any two opinions about such behaviour, and in our present state at Guy's with Rugby football at a somewhat low ebb it seems especially unsportsmanlike so to do. The football men and all those who take an interest in Guy's football (and who does not) rightly resent such a course of action, and it is to be hoped that those who are playing for outside teams and those who are contemplating so doing will think better of it.

Pupils' Physical Society.

A clinical meeting was held on Saturday, October 22nd, at 8 o'clock, in the Wills Library, Mr. P. A. Peall being in the chair.

The following cases were shown :—

Freidreich's Ataxia ... ... Mr. Mollison.
Temporal Hemianopia ... Mr. F. W. Morton Palmer.
Still's Chronic Arthritis with Enlargement of Glands. Mr. G. C. F. Robinson.
Tuberculous Tumour of Neck ... ... Mr. Burney.
Epithelioma or Syphilis of the Tonsil ... Mr Gibson.
Locomotor Ataxia ... ... Mr. Mollison.
A Case of Muscular Weakness with Atrophy. Mr. Burney,

In the discussion of the cases the following members spoke:—Messrs. Payne, A. S. Morton Palmer, Bell Walker, N. I. Spriggs, Leipoldt, Clarke, the Exhibitors, the Chairman and the Secretaries. The meeting adjourned for coffee at 10.15 p.m.

The next meeting of the Society will be held in the Wills Library on Saturday, November 5th, and will be a Pathological Meeting. Mr. N. I. Spriggs in the Chair.

Papers by Guy's Men.

A Note on a Case of Gunshot Wound. By P. H. Ward, M.R.C.S. Eng., L.R.C.P. Lond. Illustrated.—*Lancet*, 15th October.

Case of Disseminated Sclerosis of Congenital Origin. By J. M. Gill, M.D. Lond.—*The Australasian Gazette* for September, 1904.

Some Thoughts on Food and Exercise. By W. J. Tyson, M.D., F.R.C.P.—*Clinical Journal*, 2nd November.

A Case of Enlarged Liver and Glands with Purpura and Fatal Haematemesis. ? Sarcomatosis.

CLINICAL LECTURE BY DR. FAWCETT.
July 20th, 1904.

GENTLEMEN,—The case I intend to bring before you to-day is that of a boy, æt. 5 years, who was admitted into John ward on July 9th last. There was no point of importance in the family history, but with regard to the boy himself the mother said she had noticed that he "bruised" more readily than the other children.

The history of his illness was as follows:—A fortnight before admission his mother had noticed some "lumps" at the angle of the jaw, and a few days later some "red spots" were seen on the flanks. The boy soon began to lose his appetite and became rather apathetic. The rash has gradually spread but there has not been any hæmorrhage elsewhere, such as from the nose or mouth. The mother states that until fourteen days ago the boy was perfectly well.

Condition on admission.—A well nourished boy, who did not look very ill but was rather anæmic. There was a purpuric rash, distributed most thickly over the abdomen and chest, and present also on the back, limbs, and the sides of the face. The spots varied in size from a pin's head to some which were as large as a quarter of an inch across.

There was a bruise, measuring about one and a half inches in diameter, over the point of the right shoulder. Below the angle of the jaw on either side the glands were felt to be somewhat enlarged, but the largest was no bigger than a damson. Those in the axilla and groins were palpable but not enlarged. The glands along the posterior border of the sterno-mastoid could also be felt, but apart from those mentioned above no others could be felt. On examining the abdomen the liver was found to be enlarged, extending down almost to the level of the umbilicus; its surface was smooth and there was no tenderness on palpation. The spleen could not be felt.

Apart from a soft, short, systolic bruit in the pulmonary area there was nothing abnormal detected in the heart or circulatory system. All the other organs of the body were apparently healthy.

July 11th. The boy complained of pain in the upper part of the right cheek, and in the evening it was swollen and the skin over it shiny. The glands beneath the jaw on the right side were more swollen. Temperature had risen to 102·8°.

July 12th. The tissues of the face were still more swollen and the skin very shiny. The right eye was closed by the swelling of the lids, which were also stained by blood extravasated into them. The boy had become very drowsy and was obviously very ill and more anæmic than on admission. The hæmic murmur was louder than before. A blood count gave the following result—

Red corpuscles	...	2,236,000 per c.c.m.
White "	...	11,200 "
Hæmoglobin ...	...	45 per cent.

July 13th. The right side of the face was less swollen but the left was now affected, and there was a "black" eye on that side. At 12 noon about half a pint of dark blood was vomited. At 5 p.m. there was a recurrence of the hæmatemesis and again soon after 9 p.m., the quantity on these two occasions being in all about a pint and a half. Some of it was of a dark colour and the remainder bright red. He died quite quietly, shortly after the last attack of hæmatemesis. From July 11th to 13th the temperature varied between 99·8° and 103°.

Autopsy.—The report of the autopsy made by Dr. Barber was as follows:—

There was nothing abnormal in the facial bones, and no thrombosis in the veins of the neck.

Parotid gland enlarged on the right side. Submaxillary and upper cervical glands enlarged on both sides, the size of the glands varying from a half to an eighth of an inch in length. They were pale pink on section.

The thymus was enlarged, weighing 31 grammes, that is about four times more than the average weight for the age.

One of the bronchial glands was enlarged and the mesenteric glands were slightly enlarged.

The liver was smooth, pale, and soft, weighing 940 grammes.

The spleen was somewhat large, weighing about 112 grammes.

The kidneys were pale and had a strikingly "flea-bitten" appearance on the surface. On section the cortex was pale, and small hæmorrhages were to be seen in the substance of the organ.

The testes were normal, as were also the remaining viscera.

A specimen of blood taken from the right ventricle, and sent to the bacteriological laboratory for examination, was reported as showing only the presence of the bacillus coli communis on cultivation.

Here, then, we had to deal with a case of a boy of five years of age who died within three weeks of the appearance of a pupuric rash on the body. There was a much enlarged liver, the spleen was somewhat enlarged, and the cervical glands were similarly affected. Death resulted from hæmatemesis.

I do not propose to enter to-day into the diagnosis of all the pathological conditions with which purpura is associated, for you will find those fully dealt with in a clinical lecture by Dr. Hale White, and reported in our GAZETTE on Jan. 30th last. I propose to consider those conditions which were discussed by the "Clinicals" and myself in special relation to the combination of purpura and enlarged liver and glands. They were as follows:—

1. Infective endocarditis.
2. Leukæmia.
3. Cirrhosis of the liver.
4. Syphilis and tubercle.
5. Hodgkin's disease.
6. Multiple sarcomatous deposits.

1. *Infective endocarditis.*—The only abnormal sign present on examining the heart was a murmur in the pulmonary area, which we thought due to anæmia. The case, although a febrile one, did not offer any indications that the condition was due to an infective endocarditis, for example, the occurrence of rigors, enlargement of the spleen, or signs of infarction, or embolism in any of the organs of the body, or of the vessels of the extremities. It is true that in such cases a bruit may not be heard during the time the patient is under observation, and that only in the dead-house is the presence of a malignant endocarditis discovered. It is true also that a pulmonary bruit thought to be hæmic in origin, may actually be due to a pulmonary valvulitis, but such conditions are of rare occurrence, and in the absence of any symptoms to support such a diagnosis, it was put out of court.

Purpuric eruptions may be seen in this disease as well as hæmorrhages into various organs. It was possible that the fatal hæmatemesis might have been the result of a rupture of an aneurysm of one of the branches of the arteries of the stomach or neighbouring viscera, the aneurysm being the result of plugging by an infected thrombus. There is a beautiful example of such a condition to be seen in our museum,

and some of you may know the specimen. It is one of an aneurysm of a branch of the splenic artery which ruptured into the stomach, and the patient from whom it was removed was the subject of infective endocarditis. The autopsy showed that in the case of our patient there was no such cause present, and I only remind you of it here in relation to infective endocarditis and fatal hæmatemesis.

2. *Leukæmia.* — In the variety known as "spleno-medullary" leukæmia, the blood changes are characteristic, as evidenced by the presence of a marked leucocytosis associated with the so-called "myelocytes." The spleen, too, is in the majority of cases much enlarged. But in the other variety of leukæmia, the lymphatic form, the spleen is not enlarged to anything like the same extent, and this appears to especially apply to the acute type of case in which, perhaps, the duration may be only a few weeks.

In this patient we were unable to feel the spleen although there was some increase in the area of splenic dulness, but bearing the above facts in mind we were very doubtful at first whether or not the case belonged to this acute type. The glands also may not be enlarged to any great size. Examination of the blood, however, although unfortunately only one was made, showed that there were only 11,200 white corpuscles per cubic millimetre. We therefore concluded that *probably* the case was not one of lymphatic leukæmia. You might perhaps say to me that there was no necessity to qualify the conclusion by the use of the word "probably" but that the absence of a leucocytosis was sufficient. I would remind you, therefore, that in the early stages of leukæmia such an increase of white cells may not be present, and therefore, in the absence of a differential count, no certainty could exist. There are cases on record in which the only point which first drew attention to the possibility of a "leukæmic" origin was that the lymphocytes were increased out of proportion to the other varieties of leucocytes in the blood.

Another feature in which the case was like one of acute leukæmia was the bleeding. In most of them the hæmorrhage has taken place from the bowel, the nose, or the gums, and although I do not know of any case in which fatal hæmatemesis occurred, there is no a priori reason against it. Here, however, there was nothing specially characteristic, and the large size of the liver contrasted with that of the spleen together with the absence of a leucocytosis made us decide that the case was not one of acute lymphatic leukæmia.

3. *Cirrhosis of the liver.*—No doubt most of you realise the fact that a patient with this disease is apt to bleed from the mucous membranes or into the skin. Although cirrhosis of the liver is a rare disease in children, and although, as you will hear later, we did not think it was the case in this patient, yet at first the large size of the liver and the hæmorrhages made us consider it. If you will refer to a paper by Dr. Taylor in the Guy's Hospital Reports for 1895, on "Cirrhosis of the liver in children," you will there find certain features clearly set out which might be described as almost characteristic. The cases are of long duration, the signs and symptoms point to an "abdominal" condition as being the cause, and are associated with enlargement of the spleen, and sometimes of the liver, with jaundice. The duration is measured by years: the most striking feature is the great increase in size of the spleen. Now I do not mean to convey to you the impression that it is only in children with cirrhosis that great enlargement of the spleen occurs, because that is not true. The spleen is found enlarged in many cases of cirrhosis, but it does appear that in children the increased size is a more striking feature than in adults.

Again, these children are generally undersized, of sallow appearance, and have a shrivelled facial aspect. After considering these points it will be quite clear to you why we did not regard this case as one of cirrhosis, for in almost all particulars it differed from it. The progress of the case was far too rapid, the spleen was not palpable, there was no jaundice nor ascites, and the facial aspect and general condition of the patient was quite unlike that seen with cirrhosis.

4. *Syphilis and tubercle.* — As regards the former of these two there was no sign of congenital syphilis, nothing to suggest that the enlargement of the liver and glands were due to this cause, nor was there anything in the history of the patient to lead us to suspect it.

In respect of a tubercular affection although the glands beneath the jaw were enlarged, and some of these situated lower in the neck, yet there was no general enlargement nor any evidence of a generally disseminated tuberculosis. The abdominal condition also could not be explained on this hypothesis, for there were none of the signs which we commonly see with a tubercular peritonitis or tabes mesenterica, and such as might be accompanied by an increased size of of the liver from the deposit of tubercle, or from an associated perihepatitis.

5. *Hodgkin's disease.* — The usual course of this disease, you will remember, consists of an enlargement of glands which at first may be local and later may become general; also that this condition is accompanied by a progressive anæmia, often a remittent pyrexia, and sometimes with an increase in the size of the liver, the spleen, and other organs, such as the thymus gland. In the early stage of Hodgkin's disease the spleen may not be felt, and indeed may never reach any great size, but in a large percentage there is some increase and the organ becomes palpable. The disease, however, is a more or less chronic one in the greater number of cases. For example, Gowers records a list of fifty cases, in eighteen of which the duration of the disease was less than a year, while in the remainder it was one to five years, or more. On the other hand, cases are recorded in which the duration was much less than those—a question of weeks, not years. I have no personal knowledge of them, but they are said to be associated with a rapid enlargement of the glands, and sometimes with severe hæmorrhages from the nose, gums, and other mucous surfaces. There was therefore the possibility that our patient was suffering from this acute form of the disease, and indeed I cannot say even now that that was not the case. The facts that the enlargement of the glands was practically limited to the cervical region and that, while the spleen was little if at all enlarged, the liver was markedly so, made us, however, very doubtful whether it was really a case of Hodgkin's disease. The spleen weighed only 112 grammes, the liver was 33 ounces or 940 grammes. The anæmia was not by any means a striking feature of the case, but the very short duration and the purpura and hæmatemesis were.

One of the great difficulties in deciding into what class to put such a case as this is that the term Hodgkin's disease or lymphadenoma has been used to cover such a medley of cases, cases which are like what we recognise as Hodgkin's disease in one way but unlike it in another. Indeed, the terms Hodgkin's disease, lymphadenoma and lympho-sarcoma have been used so loosely that it is often extremely difficult to be certain as to what people meant by them. However, what I want to draw your attention to is that this case is not in the least like what we ordinarily look upon as Hodgkin's disease, either clinically or pathologically. It is indeed so unlike in some ways that I ventured to suggest it might possibly be one of the cases such as Dr. Fagge described in the Guy's Hospital Reports for 1881, under the title of "Purpura Hæmorrhagica accompanying the Growth of Multiple Sarcomata," or to sarcomatosis.

The post-mortem appearances in our case were also different from the typical cases of Hodgkin's disease. There was no "hardbake" spleen, nor were there any "lymphomata" to be seen in any of the organs such as the liver, the walls of the intestine and so on.

Histologically the organs had for the most part a structure like that seen in Hodgkin's disease. The glands presented a very finely fibrillated stroma with the spaces crammed with lymphocytes. I was, however, unable to find any of the large endothelial cells, with often two or more nuclei, which are said to be characteristic of the disease and to be especially numerous in the acute cases. A beautiful example of these cells is to be seen on a plate accompanying a paper by Dr. Andrewes in the Pathological Society's Transactions for 1902.

In the liver and kidneys the interlobular and intertubular tissues respectively are invaded by large tracts of round celled deposits, which separate, compress, and indeed in many parts have resulted in the atrophy and disappearance of portions of the component cell structures of these organs. The same appearance is seen in the submaxillary gland. The specimens are here under the microscope for you to see after the lecture, and I have also brought some specimens of organs from typical cases of Hodgkin's disease for you to compare with those from our case to-day.

6. *Sarcomatosis.*—Having come to the conclusion that our case did not belong to any of the conditions previously referred to, it remained to consider under what heading to place it. The general characters of the illness appeared to me more like the cases described by Dr. Fagge than any others. At any rate it will serve very well to draw your attention to his interesting paper, some of the cases in which closely simulate the one we are considering to-day.

Unfortunately the examination of the blood is deficient, firstly, owing to the fact that we were told that the boy was more apt to bleed than the other children so no examination was made on his admission, and secondly owing to his sudden death.

The chief features of the case to be borne in mind are the slight enlargement of the glands, the large liver, and the rapid progress of the case terminating with a recurrent hæmatemesis.

The blood examination showed a simple anæmia only.

Clinically, it is quite clear that the case belongs to a much more malignant type of disease than anything we recognise as belonging to Hodgkin's disease, and histologically there is a round-celled invasion of organs and tissues without, as far as I could see, any of the large "endothelial" cells which are said to be characteristic of the disease.

I will now read to you abstracts of the cases recorded by Dr. Fagge in the Guy's Hospital Reports, vol. xxv., choosing those which are most closely analagous to our patient. Dr. Fagge first points out that among the various causes of purpura attended with hæmorrhages from mucous surfaces there is to be included the rapid development of sarcomatous growths in various organs and throughout the body generally.

Case 3.—Thomas C., æt. 30, was admitted under Dr. Fagge in March, 1867. He had been in good health till the previous month, when a cough developed and the sputum was streaked with blood. From this he recovered and returned to work till fourteen days before admission, when he was suddenly seized with a dull, heavy pain in the chest which necessitated giving up his work.

March 16th. Purpuric rash on skin. A quantity of dark blood brought up without coughing.

March 21st. Urine red or nearly black and continued so.

Condition on admission (March 23rd).—Purpuric spots on various parts of the body, especially around the neck and over the præcordial region, on gums and on inner side of the cheek. Expectoration of a considerable quantity of blood, which appeared to come from the mouth. Left lobe of the liver enlarged, reaching down half way between the ensiform cartilage and the umbilicus. Spleen increased in size, the edge being felt about half an inch below the ribs.

Urine of dark red colour with red cells in abundance. He suffered later on from epistaxis and bleeding from the gums and effusion of blood beneath the conjunctiva.

March 30th. Glands of neck enlarged and tender on pressure. All the other lymphatic glands of the body are swollen but not so tender. The following day he developed an acute œdema of the larynx, to which he succumbed.

At the autopsy the cervical glands were found to be enlarged, one inch in their long diameter; the axillary glands were slightly smaller, and those about the portal fissure and at the head of the pancreas larger than normal. The mesenteric, lumbar, and iliac glands were little, if at all, enlarged. The tonsils were large and the thymus also. The kidneys were spotted all over with white patches, the spleen weighed twenty ounces, and the liver one hundred and twenty-eight ounces. Histologically the kidneys showed a small round-celled intertubular infiltration, and a similar invasion was seen on examining the liver. The pleura and pericardium were ecchymosed, the pia mater and peritoneum slightly so, and there were hæmorrhages into the intestinal coats and into those of the stomach. Dr. Fagge tells us that there was no leukæmia in this case.

Case 5.—In which there was no autopsy, is one which Dr. Fagge looked upon as belonging to the same type as case 2.

Robert H., æt. circa 25, came to Dr. Fagge in Feb. 1876. Fourteen days before Christmas, 1875, he developed a bad cold and had never been well since. The mouth and tongue were stained with blood, and the gums slightly spongy. Purpuric spots on legs, and an effusion of some size about right ankle. Two enlarged glands at back of neck.

The patient rapidly became anæmic, and the lymphatic glands in different parts of the body grew so large that the case was subsequently regarded as one of that variety of Hodgkin's disease called a lympho-sarcoma.

Subcutaneous and cutaneous growths appeared and patient had repeated hæmorrhages from the bowels.

Death took place a short time afterwards.

Case 2.—This case also might, in Dr. Fagge's opinion, come quite well within the category of Hodgkin's disease.

The case was that of a man æt. 38, admitted on May 9th, 1877, who had always been well till five weeks before, and had continued at his work till five days before admission.

May 4th.—Purpuric rash appeared on neck, groin, and legs, and blood in urine.

5th.—Epistaxis. Gums bleeding.

9th.—Purpuric rash. Urine dark purple. Epistaxis continuous. Died the following day.

At the autopsy the kidneys were pale and mottled, presenting a number of small tumours varying from dots to 1 c.m. in diameter.

There was a mass of white growth around the right vesiculæ seminalis and the vas. The cervical glands of the left side were swollen and fleshy and the omentum was studded over with ecchymosed glands.

The growth was described as consisting of a highly nucleated small celled infiltration, and the kidneys showed a similar nuclear growth.

In the remaining cases of Dr. Fagge's series, masses of growth were found in various parts, *e.g.*, in the ileum with secondary deposits in the kidneys and pericardium.

In case 2 which I have just read to you the deposit in the vesiculæ seminales was looked upon as the primary growth.

In cases 2, 3 and 5 the clinical features of the condition were like those of a case of Hodgkin's disease, whereas in the other cases they were not so.

It does not follow, as you know, that because masses of growth were situated in different parts, the case was not one of Hodgkin's disease, for in typical cases of this disease such tumours may be present in or around different organs or structures; for example, in the mediastinum, the testis, and the intestine, in addition to their presence in the spleen and the kidneys. In other cases of Hodgkin's disease no deposits are seen in the organs with the naked eye, and yet the course of the disease, the distribution of the deposits, and their histological appearances, would point to the cases being included under this disease.

Apparently in the cases of multiple sarcomatous deposits the same variations may occur; in some cases there are growths with accompanying secondary deposits, in others, such as case 3, no large masses are to be seen. Thus, what I wish to direct your attention to is that neither by the naked-eye appearances, nor the histological structure of the organs, may we be able to say "*for certain*" that a case is or is not one of Hodgkin's disease, unless it be by the presence of "endothelial cells" referred to above. Our diagnosis rests upon a combination of observations of the course and duration of the disease, and the condition of the blood.

If we look at the patient we have been talking about to-day, I do not think we can do better than sum up as Dr. Fagge did in reference to one of the cases, that "although well known that purpura, epistaxis, and other hæmorrhages occur as complications of this disease (Hodgkin's disease), I am not aware of any instances hitherto recorded in which they have been the earliest and most conspicuous symptoms."

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Tuesdays, November 8th and 15th, 1.15 p.m., Clinical Surgery, by Mr. Clement Lucas.

Saturdays, November 5th and 12th, 1 p.m., Clinical Medicine, by Dr. Hale White, and November 19th by Dr. Taylor.

Monday, November 7th, 1.15 p.m., Lecture by Mr. Brailey.

Monday, November 14th, 1.15 p.m., Lecture by Mr. Steward.

The Life-work of an 18th Century Man-Midwife.

I HAD been down to New Romney to arrange some exhibits for the museum of the Annual Meeting of the Kent Archæological Society, and my friend, Dr. Hick, who was on the local committee said: "Oh, if you are fond of this sort of thing, old Miss Buss has a book you would like to see; its a manuscript list of all the confinements attended by a man named Waylett who lived at Lydd." The two names were quite sufficient. The old lady was the daughter of the late landlord of the New Inn, and her fame for good cooking was known throughout that fifth quarter of the globe which, according to Barham, is called Romney Marsh. Of Waylett, I had heard from my friend and master the late Dr. Terry, who, born in 1806, had seen him when a child. I also remembered that among a bundle of local MSS. I had a small volume which had been his working pharmacopœia. So I went round to the Almshouses where my friend lived, and after a chat and a look at her eyes, which were both cataractous, and a little advice on the same, I asked her about the book. She soon brought it out. It had come to her from a relative who was a descendant of Wm. Waylett's assistant, Thomas Sargent. The book is a fair sized quarto with brass clasps mounted on leather thongs. It is bound in black calf. As soon as I saw it I knew that it was a 17th century book of the same size and binding as the "preacher's bible."

On opening the book the right way, on the end paper is written Wm. Waylett, 1658, and again on the next leaf with the date a year earlier. On the top of the leaf is the price of the book, 2s. & ivd. Multiply this by two and a half and you get the modern value of 6s., which is what a MS. writing book in similar binding would now cost. This end of the book is made up of prescriptions for the various ills that mankind is heir to, with very precise directions for their use and "an epitome of the whole course of Phisicke." This latter is an enlargement, by way of question and answer, of the Apophegms of Hippocrates, brought as near as possible to the teaching of that day. The first question and answer will give a taste of its quality.

Doctor: "Seeing you are desirous to be admitted to the practise of phisick; let me heare how you are fitted for soe noble an Art; for every man is not fitt to be a Phisition according to the proverbe Ex quolibet ligno non fit Mercurius: therefore tell me First What manner of man a Phisition must be."

Student: "A Phisition must be learned, Judiciall, Sober, of honest conversation not full of wordes but secret, chast, truely religious not covetous or given to wine and finally, he must be a Phylosopher according to the saying, Noli desinit Philosophus incipit Medicus." To this I add, Ad amussim convenit exemplo.

On turning the book round we find the first thirty pages filled with the obstetrical list of a second Wm. Waylett, dating from 1757 to 1815. It is headed, "A List of Women delivered by Wm. Waylett since settled at Lydd."

He divides his head line into columns—Date, Name, Place, Month of Pregnancy, Character of Labour and Presentation, Sex of Child and Number of Pregnancy. Last column of all, The fees paid or unpaid.

During the last twenty years he was assisted by Thomas Sargent, who succeeded him finally in the practice. The total number of deliveries was 2,863, of these Sargent attended about 500. If we take the headings given the "natural" labours were 2,462 and the remainder were "*Lingering*" and "*Laborious*," 311. "*Quick*," 4. "*Præternatural*," 16, two of these were twin cases. *Flooding*, 3. *Twins*, 24. "*Rigidity*," 5. *Deformed mother*, 2. *Dead full-time children*, 15. *Breech cases*, 16. *Footling*, 5. *Arm*, 2. *Face*, 3. *Prolapsed cord*, 1. *Shoulder*, 1. *Deformed male fœtus*, 1. *Scirrhus placenta*, 1. *Forceps*, used five times. *Abortion* mentioned as such, three, and the following *untimely births*—

Month ..	3	4	4½	5	6	6½	7	7½	8	8½
Number .	1	1	1	5	17	7	38	15	26	5

making a total of 115 premature births.

According to Parr's Medical Dictionary, 1809, "Laborious" and "lingering" labours are those protracted beyond the usual time or requiring extraordinary assistance. "Præternatural," when any part except the head presents and requiring also obstetrical aid. "Natural" labours are those when the child is delivered by the efforts of nature. I am afraid that these definitions are more or less contradictory, but the practical result is that when the list comes to be analyzed the "natural" births amount to 2,344, and the "unnatural," if I may lump all the other headings together, to 519, or about 5 to 1. But if we look at the list with modern eyes the labours were all natural except 86, which is almost exactly 3 per cent. of the whole. I expect that the "lingering" and "laborious" labours (311) or about 1 in 9 would now be all terminated by the forceps. In the same Dictionary directions are given for the use of the forceps. They were looked on as almost a last resource, and the woman was not to be relieved by them until she was practically exhausted. The forceps used by Waylett would be those of Smellie, the short straight forceps, and they would not be applied unless both ears could be felt. The long straight forceps, and the high application of them, were only mentioned with fear and trembling. These short straight forceps were often covered with leather to prevent bruising. A few years later they were made uncovered and roughened so that they might not slip. Unfortunately, our author has not added a column for "results," so that his case-mortality is unknown. Probably it was not high, as the district he worked in was an agricultural and seaside one. The only suspicious series is that of the two first wives of one man, who both had "præternatural" labours for their first and only child, and don't appear again, but the third wife does, and repeatedly. Lastly, we come to the column for fees. The ordinary fee was half-a-guinea, which was still the Poor Law fee when I first went into the country to learn the art of the general practitioner. The highest fee received was four guineas and that apparently for a special case. The fee for the better class gentry and beneficed clergy was two guineas. A little more was charged if the patient lived at a distance. A six-mile journey across the marsh brought in an extra five shillings, a ten-mile trip along the coast produced a whole guinea, or now and then a guinea and a-half. There were absolutely no hard roads then, and all journeys had to be made on horseback. The practice, and I have worked in it at times, is one of the hardest and poorest in the south of England. It is worth noticing that the only cases of flooding mentioned all occur on the first page of the list. We are all a little inclined to have abnormal cases in our early practice, but one is tempted to think that Waylett was either very skilful for his time, or lucky in his cases, or possibly he, with many of the older practitioners, did not consider hæmorrhage "a flooding" unless the patient was extremely depressed by it.

Now let us see if we can find out anything about the old man. Dr. Terry told me that Dr. Waylett was the last man in the neighbourhood to wear a "double decker" wig, that is one with two rows of curls at the bottom, like that still worn by state coachmen (I have one of a great grand-uncle who died in 1819); and that he always walked about with a daisy in his mouth. I remember this practice being kept up in my youth by several old gentlemen in this same town of Lydd, one in particular who carried a piece of lavender in his mouth to church. It is an interesting point to remember, because it was done by way of prophylaxis, and belongs to the same category as the herbs strewed on the ledge of the dock in front of the prisoners, and the nosegays of the same presented to the judge at the trial, which were supposed to keep off gaol fever. This custom was kept up in the courts till quite recent years. A relative of mine dying of cholera Asiatica, the only man of the eight who carried his coffin who caught the disease, was the one who would not have a bunch of lavender and wormwood fixed under his chin to smell at, so I was informed some years back by one of the other bearers. Well, this by way of digression; I am afraid my tale, if put into graphic form would not look unlike the celebrated diagram to be seen in "Tristram Shandy." To return to our hero. He was evidently a man of some character and importance, as he served the office of Bailiff six times before 1790. N.B.—Bailiff = Mayor nowadays. And on looking up a local directory published at Canterbury in 1776, we find that "The best houses in the town are those of Mr. Mark Skinner, Mr.

Robert Cobb, and Mr. William Waylett, a Gentleman of great skill and judgment in Surgery and Pharmacy."

He died unmarried in October, 1815, and was buried in the chancel of the church, at the age of 86, having come to Lydd when 28. I could find no reference to him at the Apothecaries' Hall, so in all probability he was one of the men who qualified by apprenticeship. The last entry in his list is for January 29th of the same year, the year before he had attended 20 women. A brave old man! But, says pale envy, looking over my shoulder, is there no scandal attached to his name? The recording angel's ledger has been examined, but there is no entry. The day-book certainly has his name put down, but it is crossed off, and there is a great splutter of ink next to it and a note stating that pens made from the quills of the accusing angel were very bad ones, also something that looks very like a condemnation of tale-bearing.

F. WILLIAM COCK, M.D., F.S.A.

The Examination of a Chylous Ascitic Fluid.

By A. ZORAB and S. W. DAW.

With an account of the case by J. M. Brydone, and a note on Milky Ascitic Fluids by E. I. Spriggs.

Clinical account. — Mrs. A., æt. 35, married, with three healthy children from fourteen downwards, was admitted into Bright ward with the idea of attempting to cure her of an intractable ascites by tapping and irrigation with saline, the diagnosis having been made of chronic peritoneal effusion, possibly tuberculous, by a consulting physician.

History.—Ten months before she thought she was pregnant, her abdomen having increased in size. At the expected time no labour resulted and examination revealed a large amount of free ascitic fluid and no pregnancy. She was tapped twice, the fluid reaccumulating, no difference from ordinary ascitic fluid being noted about it. She was admitted on February 17th, 1903, into Bright ward.

She was emaciated but otherwise healthy in appearance. The abdomen was uniformly distended by free fluid, which gave a thrill easily in all directions and altered its position with that of the patient. No tumour was definitely felt, but through the ascites I convinced myself there was a lump. The base of each lung was dull and the heart somewhat pushed up. There was orthopnœa, due to the pressure caused by such a large collection. It was thought to be a sarcoma of the ovary.

An anæsthetic was given for the double purpose of tapping and forming a diagnosis, as the patient was very nervous, but she bore it extremely badly and artificial respiration had to be resorted to. A few days later she was tapped, and from the abdomen and left pleura came abundant milky fluid. There was over five pints in all, leaving a very large residue, and a small quantity was demonstrated by a needle to be in the right pleura also. She was tapped three times more in five weeks, and gradually the ascites disappeared enough to allow her to go home better than on admission. Dr. Hale White gave a bad prognosis and advised no further exploration, on the ground that the involvment of the pleura contra-indicated operation, giving his opinion that it was most probably sarcomatous. Pil. Hyd. Diuretica and Copaiba were used but had no influence at all: her appetite was good and digestion fair. She went home in April, able to get about the garden and look after the house.

In July the ascites and chylothorax had completely vanished. The abdomen, which had become quite small, was occupied by an enormous spleen running down into the hypogastrium and a very enlarged liver. The diagnosis seemed to lie between sarcoma and some form of cirrhosis. She got weaker, without ascites, and died without pain or further symptoms on November 9th, 1903, being fairly active to the end.

March 18th. Weight, 9 stone 4½ lbs. Greatest girth, 41 inches.

March 31st. Weight, 9 stone 1⅛ lbs.

April 6th. Weight, 8 stone, 12¾ lbs. Greatest girth, 38½ inches.

All the improvement dated from the second tapping. The fluid clotted quickly and was always the same in appearance while she was in the hospital. The liver and spleen were not palpable after the tappings, but an umbilical resistance was just definite. The temperature was never raised. She was in hospital fifty-one days and improved after eighteen days.

A post-mortem examination was made by her doctor and growth (sarcoma) was found scattered through the body, apparently primary in either the spleen or the ovary, but the investigation left much to be desired in the direction of the possible origin of the chyle, if chyle it was.

The chief interest lies in the sudden development of the chylous change within four weeks of a normal tapping, the remarkable change that came over her when at her worst, and the complete disappearance of the ascitic fluid.

J. M. BRYDONE.

INVESTIGATION OF ASCITIC FLUID.

The following is an analysis of the fluid.

1. *Reaction to litmus.*—Neutral.

2. *Specific gravity.*—As a mean of three experiments—the s.g. bottle being used—the specific gravity was found to be 1016.

3. *Formed elements.*—Some of the fluid was centrifuged and examined microscopically, but no formed elements or droplets were seen. The fluid had a fine granular appearance like ground glass and stained uniformly with Sudan iii.

4. The fluid was allowed to stand in an ice-chamber for a week, and was then found to consist of two layers:—

(*a*) The upper layer or "cream" was of a greyish-white colour, and formed about one-eighth of the total volume.

(*b*) The lower layer was rather dirtier in appearance, and formed seven-eighths of the total volume. It had a faint tinge of green about it.

Both layers were quite opaque.

5. When some of the fluid was slightly warmed in a test-tube with a few drops of 40 per cent. NaOH, and, after cooling, ether was added, the opacity of the fluid was entirely removed, and a drop of the ethereal extract was found to leave a "grease spot" on filter paper. From this it is probable that the opacity was, in great part, due to fat.

6. *Estimation of percentage of solids.*—200 c.c. of the fluid was carefully dried in a weighed capsule, first at 100° in a water bath for 48 hours, and then at 110° in an air bath for 24 hours (the fluid having previously been rendered slightly acid to prevent loss of nitrogen or ammonia). The yield of dried product was 12·662 gms. The weight of 200 c.c. of the fluid (s.g.=1016) was 203·2 gms., so the percentage of solids works out at 6·24; thus:—

$$\frac{12{\cdot}662 \times 100}{203{\cdot}2} = 6{\cdot}24.$$

7. *Estimation of nitrogen and hence of proteid* (*Kjeldahl*).—·5 gm. of the dried product was taken in each of the two estimations made, and the mean of the two results—which were sufficiently close to confirm each other—gave a percentage of 8·1 of N. in the dried product. Taking 6·25 as the factor which is usually accepted for calculating the amount of proteid from a given quantity of nitrogen, the percentage of proteid, in the dried product, works out at 50·62, and this gives a percentage of proteid (in the original fluid) of 3·16.

8. *Estimation of fat* (Liebermann's method).

The proteid was broken up and all fat converted into soap by boiling with strong KOH. The soap was then converted into fatty acid with H_2SO_4, the fatty acid extracted with petroleum ether and converted to soap again by accurate neutralisation with standard alkali. Lastly, the soap thus formed was carefully weighed in a closed vessel. From this the percentage of fat can be calculated.

As a result we found that the percentage of fat was 22·61 in the dried product, or 1·24 in the original fluid.

Summary:—

(1). Reaction—neutral.

(2). Specific gravity—1016.

(3). No formed elements.

(4). Percentage of solids—6·241.

(5). Percentage of proteid—50·62 in dried product, 3·16 in original fluid.

(6). Percentage of fat—22·61 in dried product, 1·24 in original fluid.

S. W. DAW.
A. ZORAB.

A considerable number of cases of milky peritoneal effusions has been described. A classification is made into (1) Chylous ascites, and (2) Chyliform, or pseudo-chylous ascites, according as the opacity is due to fat from the lacteals or to some other cause.

In the *chylous* forms a layer of cream separates on standing, and when caustic soda and ether are added the cloudiness clears up completely on gentle shaking. Under the microscope two different appearances may be seen; either fat droplets which stain with osmic acid and with Sudan iii., or a very fine emulsion of fat, showing no droplets but only very fine particles which also stain; if a little ether be added these particles run together and form droplets.

Varying proportions of fat have been observed up to 4·3 per cent. Letulle states that opalescence is not caused unless there is ·15 per cent. present. This figure is probably rather too low, for Bernert points out that perfectly clear blood serum may contain ·19 per cent. of fat.

Since the fat is suspended in an ordinary ascitic fluid, a coagulum of proteid is obtained on boiling and adding a drop of weak acetic acid. The quantity of proteid varies from ·4 to nearly 10 per cent., and is higher in inflammatory effusions than in those due to obstruction only. The most is contained in peritonitis associated with cancer, where both conditions are present.

The proportion of total solids is higher, 5 to 10 per cent., in fat containing fluids than in the pseudo-chylous, 2 to 5 per cent., just as there is more solid material in chyle than in ordinary lymph. Both chylous and pseudo-chylous fluids yield about the same amount of inorganic salts.

If the blood serum, the exudation in the peritoneum or the pleura, and also the urine be cloudy, the cause is most probably fat; the non-fatty, milky effusions are usually local and involve the abdomen only or the abdomen and thorax.

The cause of chylous effusions is the escape of chyle from the lacteals, due to obstruction of them or of the thoracic duct. Such obstruction arises from abdominal tumours and from the presence of the filaria sanguinis hominis. A moderate opalescence is said to arise in the young from lipæmia due to a milk diet: the blood plasma, as after any fatty meal, may contain emulsified fat, and some of the particles are exuded into the ascitic fluid. The presence of fat has also been recorded, due to the fatty degeneration of cells. The above case is therefore one of the chylous variety.

The pseudochylous or chyliform fluids are not so opaque as the chylous and are often yellowish or green. This simply means that the original colour of the fluid in which the particles are suspended can be seen more plainly. They contain only a small amount of fat, from ·01 to ·3 per cent. There may be a thin layer of cream on standing. The specific gravity is usually from 1010 to 1014. On adding ether and caustic potash the opalescence does not clear up. The acrolein test is negative or faint.

Microscopically fine dust-like particles are seen, showing Brownian movement, not staining with fat stains, and not running into droplets when ether is added. Centrifugalisation or passing the fluid through filter paper will not cause the suspended particles to separate. This may, however, be effected by filtration through porcelain or by dialysis. Dialysis causes the globulins present to be thrown down and the suspended particles are deposited as well. The precipitate is proteid in nature and in some cases is a globulin. The opalescence has been ascribed to lecithin but in most analyses reported of late this explanation has been negatived. Bernert, following Micheli and Mattirolo, speaks of an altered aggregation condition of the proteid and suggests that a combination of globulin with lecithin is responsible. In Hutchison's case, and in one recently described by Achard and Laubry, a nucleo-proteid was present. When the ascitic fluid is mixed with the contents of ovarian cysts pseudomucin is present and may cause opalescence.

Pseudo-chylous effusions have been observed in cases of tuberculous peritonitis, growths in the abdomen, cardiac disease, cirrhosis of the liver, and nephritis. In a number of cases no diagnosis of the cause has been made, as the condition is by no means necessarily fatal.

Several instances of milky effusion in the pleural as well as in the peritoneal cavity have been recorded. The fluid drawn is often clear at first tappings, and opaque at later ones, as in this case. The reverse has also been observed.

In both chylous and chyliform varieties, if there is any sediment it is scanty and consists of leucocytes and endothelial or growth cells. These fluids are remarkably resistant to putrefaction.

No mention has been made of milky ascitic fluids due to pus. In a case recently recorded by Songues, leucocytes were the cause of the milkiness. This would, I think, usually be called a purulent effusion.

Some papers on milky ascites :—

Letulle : Revue de medicine, 1885.

Micheli & Mattirolo : Revicta critica di Clinia Medica, 1900, I. Gazetta degli Ospedali, 1901, and Wiener Klin. Wochenschr., 1900.

Hutchison : Path. Trans. 53, 1902, with references.

Poljakoff : Fortschrift d. Medicin. 21, 1081, 1903.

Christen and Strauss, reported in Biochemisches Centralblatt, I., 1903.

Achard & Lawbry ; Centr. f. Allgem. Pathol. und Pathol. Anat. 14, 770 & 778, 1903.

Songues : Ibid. S. 770.

From the Gazette's Special Pathologist.

NOTICE.

H.R.M. Hastings. — This specimen contained a moderate number of tubercle bacilli.

PATHOLOGIST.

Notice.

UNIVERSITY OF LONDON.

Francis Galton Research Fellowship in National Eugenics.

A Research Fellowship has been founded by Mr. Francis Galton, F.R.S. to promote the Study of the National Eugenics, *i.e.*, the study of the agencies under social control that may improve or impair the racial qualities of future generations either physically or morally.

The Fellowship is established on the following conditions :—

(1). The value of the Fellowship is £250 per annum ; it is tenable for one year in the first instance, and for two subsequent years on favourable report from a Special Committee at the end of the first and second year's tenure respectively.

(2). The endowment not absorbed by the stipend of the Francis Galton Research Fellow, amounting to about £250 per annum, will be placed at the disposal of the committee for the purpose of aiding his work, subject to the general approval of the Senate.

(3). The duties of the Fellow will be to devote the whole of his time to the study of Eugenics, subject to the approval and under the general direction of the Committee.

In particular he will be required :—

a. To acquaint himself with statistical methods of enquiry, and with the principal researches which have been made in Eugenics, and to plan and carry out further investigations thereon.

b. To institute and carry on such investigations into the history of Classes and families as may be calculated to promote the knowledge of Eugenics.

c. To prepare and present to the Committee, though not necessarily for publication, an annual Report on his work ; and to give from time to time, if required or approved by the Committee, short courses of Lectures on Eugenics, and in particular on his own investigations thereon.

d. To prepare for publication at such times and in such manner as may be approved by the Committee (and at least at the end of his tenure of the Fellowship), a Memoir or Memoirs on the investigations which he has carried out.

Applications for the above Fellowship must be sent in duplicate, accompanied by copies in duplicate of not more than three testimonials, and must reach the University not later than November 10th, 1904. Additional references may be given.

ARTHUR W. RUCKER,
Principal.

In Lighter Vein.

MONOLOGUES.

"The Boro' Matron."

Wot! do I know the 'orsepital! Do I know the nose on me bloomin' fice? Wy, I've walked there, I've bin carried there, and I've bin druv there. Yus, and in a proper keb, too! None o' yer silly barrers drawn by a moke wivout a smile, and where yer has to be sorted out from the wegetables when yer does get there. Yus, I once went in a keb, I did, and there wuz a nice young copper come along o' me to sort o' keep me company. 'E wuz the one wot took my man to the stytion about a year before. I'd scratched 'is fice for 'im then, and we both remembered it, so we felt sort o' pals like.

"Polly," sez 'e, "don't yer fight so much. If yer'd 'ad more respec' fer yerself yer wouldn't 'ave gorn and bruk yer bloomin' leg," 'e ses.

"Garn," ses I, "the other lidy shouldn't 'a swore at me so drefful."

My dear, you jest should 'ave 'eared 'er swear. "Susan Grubbings," ses I, "I never would 'ave believed as 'ow a well eddicated and strickly proper young lidy could use sich orful langwidge."

Wy, even my man ses it improves 'is mind to listen to 'er! Yer see, 'er farver, 'e come from Billingsgate, and 'er muvver, she 'ails from Roverhive; so I suppose she sorter combinates the two, like.

'Owever, wot I wanted ter tell yer abaht is wen I tuk me first boy to ve 'orsepital. 'E'd fallen down and cut 'is knee, so 'e 'ad, and 'e said it 'urt 'im somethink crool. I wouldn't 'a minded *that* so much, on'y 'e went an' done it in 'is 'ollerdays.

If 'e 'ad on'y waited a week longer 'e would 'ave got orf two or free days' schooling, but ven 'e allers were a fool, wuz 'Enery Halgernon, and yer carnt mike a sow's ear out of a silk purse, can yer?

Well, I tuk 'im to ve 'orsepital, and we see sich a nice doctor. I don't know 'ow much of that there blue stuff 'e used, but it wuz a rare lot; and then 'e bandaged 'im up so beautiful, used a bandage and an 'arf, 'e did. Ow 'e must 'ave bin a clever young gent! An' 'e spoke so nice, and guv 'im some med'cin wot looked like milk, it were so white. And wen I told 'im that I thought I wuz ill, cause I allers felt kind o' weak like, arter fourteen hours washing, 'e sed 'e noo jest wot was the matter with me, and 'e give me some stuff to increase me appetite. If 'e 'ad on'y given me somethink else to tike awye me appetite I should a bin quite 'appy. But there, I musn't grumble; 'e done 'is best, I dessay.

I fink ve 'orsepital is a werry decent plice on the whole, but they are so werry funny abaht tiking fings in to yer friends.

When my second boy, Halbert Heddard Hawgustus, went and got 'is shin broke, they let me tike 'im in oranges and nuts and sich like. But wen my little gal, Matilda Beatrice, was in there, they wouldn't let me tike 'er nuffink, and she wasn't near so bad as Halbert Heddard, cause she 'ad no pain at all and felt "'ungry." She on'y 'ad typhoid, and yet they wouldn't let me give 'er as much as a coker nut. So ridic'lous of them.

O' course, I can allers give my childring nice fings, cos' my man is sich a liberal bloke. Wy, 'e on'y gets thirty bob a week, and yet 'e gives me ten shillin' a week reg'lar, and orl I 'as to do wiv it is, pye the rent, clothe the kids and meself, and git the grub! Wot d'yer think of that for generosity? I lay your man don't give yer so much. Wot's that? On'y gives yer money wen 'e's drunk? Yus; I thought that was abaht the figger.

Nah, *my* bloke is wuth orl ve uvvers put together. 'E never get's drunk except on Saturdays and Sundays, and 'e never 'its me unless we 'ave comp'ny, and o' course, a man carnt be respected unless 'e does that! 'Is pals orfen arsk 'im "Wots the good o' keeping a wife unless you knock 'er abaht abit?"

"THE WANDERING JEW."

Papers by Guy's Men.

An Address on the Methods of Acquiring Knowledge; Its Helps and Hindrances. By Philip H. Pye-Smith, M.D., F.R.S.—*British Medical Journal*, 8th October.

The Influence of Peripheral Nerve-irritation upon Diseases of the Skin. By G. Norman Meachen, M.D.—*Ibid*, 15th October.

The late Doveton Martin.

DR. H. A. MARTIN begs to thank the many old Guy's friends of his late son Doveton who expressed their kind sympathy with him and his relatives in the gratifying obituary notice in your issue of the 22nd.

Some particulars of the sad occurrence have since been received from the Chartered Company's agents at Salisbury, South Rhodesia, stating that Dr. D. A. Martin had arrived from Mwomboshi, in North East Rhodesia, on his way home on leave, having walked the distance, about three hundred and fifty miles, on foot. He appeared to be in perfect health and the best of spirits. He was staying at the Queen Hotel awaiting the arrival of the steamer at Beira, in which he had booked his passage home, and was to have left on the 14th of September, the date of his death. He had retired to bed on the previous night in his usual good health and spirits, and was found dead the next morning lying on the floor of his bedroom fully dressed. A Dr. Stewart was summoned and certified cause of death to be from "Syncope." His remains were interred in the cemetery with all rites, and were followed by the four doctors in Salisbury and many friends he had made during his short stay.

A slight error appears in the obituary notice in stating that he was Medical Officer at Salisbury, whereas he was in the Chartered Company's service, and spent four years in N. E. Rhodesia.

He had "trekd" on foot several thousands of miles, and had usually done his twenty to twenty-five miles a day, which, in such a trying climate, in all probability must have overtaxed his strength causing his sudden collapse.

To add to the distress of this sad blow, two letters have been received from him, the first reporting his safe arrival at Salisbury, in which he said he felt as hard as a brick and much the colour of one, and was looking forward with such delight to seeing all so soon.

A correspondent writes to us as follows:—

D. A. MARTIN was one of the cheeriest souls imaginable, and his fund of anecdote and powers of imitation were considerable. He had the faculty of telling a tale better than ninety-nine out of a hundred people.

The writer had a patient some time ago who had just returned from Rhodesia, and who said that he was pulled through many severe attacks of fever and other illnesses which he managed to contract in a particularly unhealthy district, not only by Martin's unremitting medical skill and nursing of him night and day, but also by his unflagging good spirits and optimism. He said he was unselfishness itself, and would come round with a temperature of 102° himself to see his patients and drag them out of their slough of despond into good spirits and a hopeful view of things by a few yarns. He confidently asserted that without a doubt he should have given up and died but for Martin's cheeriness and influence. He was extremely popular out there, and the men were really devoted to him, and deservedly so.

At Guy's he was chiefly known for his boxing, and his boxing was chiefly characterised by his pluck. At that time, 1888 to 1903, the boxing club was only just started and was in a pretty flourishing condition, having several pretty useful men, and Martin would be found every afternoon at 4.30 raking men out of the smoking room into the gym. He was a fairly clever fighter, and it was only when he got into really good company that he found his match. His capacity for taking punishment was only limited by his power of retaining consciousness. The writer saw him in an open light weight competition at the Orion Gymnasium. He met a man who won the championship, and who was considerably better than himself. Rarely has a man taken as much punishment as Martin took, and never has a man taken it better. Time after time he got up from the boards with his cheery grin and sailed up to go down again, and when the referee, who had let it go on much too long, at last stopped the fight, the audience cheered themselves hoarse for his splendid pluck and good temper.

He said himself, "I'm never beaten till I'm outed," and that's a motto he carried out of the ring into the outer world, and it was that sentiment which pulled him and his patients through in Rhodesia.

That phase of him, together with his unselfishness and his invaluable sense of humour, made him a man whom, once you knew him well, you never forgot.

There will be many who read of his death, who have often looked forward to seeing him some day as one of the men they did really hope to see again.

You couldn't pick a man better fitted to help make empire out on the fringes of civilisation, and it must have been a great compensation to many a man out there to have so good a fellow all through as Martin for their doctor.

Guy's Physiological Society.

A well attended meeting of the above Society was held on the 20th October, when it was announced that the President's prize for 1903–04, had been awarded to Mr. J. L. Rankine, for his paper entitled "Pain."

Mr. Martyn Lobb then read a paper on "Temperament," especially as regards its external physical characteristics. An interesting discussion amongst the members followed.

On the 1st Nov., Dr. T. G. Stevens in the chair, Mr. P. S. Price read a highly interesting paper on "Physical Degeneration." He dealt largely with the report of the recent Commission.

Many members took part in the discussion which followed.

The next meeting of the Society will be held on Tuesday, Nov. 15th, when Mr. R. C. Edsall will read a paper on "Diet."

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Letter from a recent Contributor.

DEAR SIR,—I have noted the following misprints in the essay on "The uses of Electricity and Light in Surgery" in the GUY'S HOSPITAL GAZETTE, September 10th and 24th.

September 10th, page 368, col. i., line 17 from bottom, for qualitative read quantitative. Line 14 from bottom, for quantitative read qualitative.

Page 369, col. ii., line 13 from bottom, for plug read plung.

Page 370, col. ii., line 26 from bottom, for Henry Fenerick read Hurry Fenwick.

Page 371, col. i., line 27 from bottom, for brake read back.

September 24th, page 405, col. ii., line 23, for Barry read Bang; line 30, for minor read micro-(organism).

Page 406, col. i., lines 19 and 23, for computed read completed; line 18 from bottom, for erythematosis read erythematosus.

Page 406, col. ii., line 22, for Barry read Bang.

Page 408, col. i., lines 27, 40 and 45, for Mayon read Mayou; line 42, for Haale read Haabe; col. ii., line 20 from bottom, for Sederhabin read Sederholme; last line, for appreciable read applicable.

Page 409, col. i., line 8, for Scholefied read Scholefield.

Page 410, col. i., line 20 from bottom, for recovered read recurred, for dozen read deeper.

Page 410, col. ii., line 25 from bottom, for Menill read Merrill.

Page 411, col. i., line 22, for "caries" read cases (no inverted commas); col. ii., line 18, for operation read operable case.

I shall be glad if you will publish this list of corrections, as many of the errors seriously affect the meaning of the sentences in which they occur.

Yours truly,

October 15th, 1904. J. SEPHTON COOPER.

[We deeply regret that the above errata should have crept into so interesting a paper as that of Mr. Cooper's. At the same time we cannot help feeling that he has himself to thank very largely, for not only is his writing apt to be illegible, but also he made no arrangements with regard to the proof correcting of the second half. Even when one is on a holiday, it is safer to correct the proofs of so technical a treatise, or at least to leave your address with the editor.—ED.]

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. R. O. Williams (Dr. Taylor); H. D. Wyatt (Dr. Hale White); A. R. Wilson (Dr. Pitt); A. D. Crofts (Sir Cooper Perry).

Clinical Assistant in Surgical Wards.—Mr. R. W. Allen (Mr. Symonds).

Ophthalmic Dressers.—Messrs. R. E. French, E. C. Hughes (Mr. Higgens, November 1st); F. Rogerson, B. H. Wedd (Mr. Brailey, November 1st); B. W. Lacey, T. Turner (Mr. Higgens, December 16th); M. de L. Robinson, F. Barnes (Mr. Brailey, December 16th).

Surgeons' Dressers.—Messrs. H. G. Gibson, P. S. Mills, P. C. Litchfield, C. De Villiers, E. Alban, A. W. Eyles (Mr. Lucas); A. S. Morton Palmer, S. Reader, H. F. Vandermin, T. H. Barton, W. H. Trethowan, A. Berry (Mr. Golding-Bird); A. G. Jones, A. S. Bankart, C. M. Ockwell, J. S. Bookless, T. F. Wilson, G. Wacher (Mr. Jacobson); W. Welchman, A. Walker, C. Ponder, E. C. Lowe, E. M. Harrison, W. H. Robinson (Mr. Symonds).

Civil.

BLACHFORD, J. VINCENT, M.D., M.R.C.S., L.R.C.P., has been appointed Medical Superintendent of the City and County Asylum, Fishponds, Bristol.

COLE, PERCIVAL P., L.R.C.P. Lond., M.R.C.S., has been appointed House Surgeon to St. John's Hospital, Lewisham.

SHENTON, EDWARD W. H., M.R.C.S. Eng., L.R.C.P., ha been appointed Radiographer to St. Peter's Hospital for Stone, Henrietta Street, W.

WILLS, KENNETH, M.A., M.B., B.C. Cantab., L.R.C.P. Lond., M.R.C.S., has been appointed Physician to the Skin Department of the Bristol General Hospital.

Guy's Hospital Dental Society.

The first meeting of the Session took place on Friday, Oct. 14th, at 4.30, the President, Mr. R. Wynne Rouw in the chair.

The President gave an opening address which was listened to with great interest and heartily applauded. A paper on "Metal Dies, and some methods of using them," was then read by Mr. W. J. Bollard.

Casual communications were also shown by the following:—Messrs, J. A. Williams, A. Alan Forty, and J. W. Mawer.

Reviews.

The price of books submitted for review should in every case be stated.

Students' Handbook of Surgical Operations. By Sir Frederick Treves, F.R.C.S. pp. 486 and xii. (Messrs. Cassell & Co.) 7s. 6d.

This is a second edition of the well-known handbook, which has been extensively revised by the author, and Jonathan Hutchinson, Junr. This revision has produced shortening of the book—a result unusual in such cases, but a very great number of additions have been made, and many articles have been rewritten and considerably expanded, room being gained for this purpose by the omission of many useless operations. The principal additions are chapters on Excision of the Appendix, Treatment of Chronic Otitis Media and Radical Cure of Hydrocele: in the former we notice that the author considers a "cuff flap" previously turned down, a perfectly useless covering for the stump of the appendix, which he considers must be invaginated into the cæcum by some Lembert's sutures placed in the wall of that viscus, while at the same time he condemns the application of carbolic and the cautery.

It is difficult to know on what lines the operations have been chosen for inclusion in this book, as the major operations that the ordinary practitioner will ever perform could be counted on the fingers of his two hands; while one hand would suffice for those he might be called on to do at a moment's notice. And yet the author has left out ligature of the Temporal and Internal Carotid Arteries, while he has inserted Excision of the Gasserian Ganglion.

Nearly thirty new diagrams have been added, most of which are excellent, but the greatest change has been made in those sections dealing with abdominal surgery, as might be expected, considering that the last edition came out twelve years ago. We wonder if it is a correct observation that—after trial of "Murphy's Button" most surgeons have . . . returned to the use of direct suture, as such is not we think true at Guy's. We particularly like the description of the operations for Excision of the Tongue, where, however, Kocher's operation is not mentioned, and Tracheotomy: in the last the operator is advised to steady the cricoid cartilage by means of a sharp hook, though its use has now been abandoned at many of the fever hospitals. In the section of urethral surgery Cock's operation has been omitted from this edition, and internal urethrotomy added—a doubtful benefit. Several unnecessary amputations have been omitted, and we are told that in ligature of arteries it is far more important to pass the needle "away from the forceps" than "away from danger."

Thoroughly revised and brought up to date, this manual is now the best possible for use at operative surgery classes.

The Diseases of Women. By J. Bland-Sutton, F.R.C.S., and A. E. Giles, M.D. pp. 520. (Messrs. Rebman, Ltd.) 11s. net.

This work, which has now reached a fourth edition, is noteworthy as having been the first attempt to reduce the study of gynæcology to a strictly pathological basis. Diseases are described and classified according to the actual state of things existing, rather than from the point of view of symptoms or causes. One result of this—especially welcome to the student, is a reduction in the number of varieties of different diseases: as, for instance, only four varieties of vaginitis, instead of the more usual nine, are described. Throughout the book there is a tendency towards the elimination of *text-book diseases*, so often the result of copying from one author to another. Bacteriology is more fully treated than in other books, a very good description of the *Bacillus Vaginæ* being given; the fact that it is not found in the lochia being pointed out, as rendering a puerperal woman more liable to septic infection. The anatomy of the genital organs is described in thirteen pages, which it would have been much better to omit, as its scope is hardly adequate, and such a description belongs more properly to the province of the anatomist. We are introduced to a new pathological condition of the uterus, called *Adeno Myoma*, in which the uterus is invaded by a growth resembling a submucous fibroid, but lacking the typical encapsulation. The clinical teaching in the book does not always agree with that which is usually given; as we are told that a rupture of the perineum is a direct cause of prolapse, and that a Hodge's pessary acts partly by pushing up the uterus in the posterior fornix. All the ordinary gynæcological operations are described at the end of the book, but the authors only give those which they use, omitting several old classical operations which have fallen into disuse. Among other rules we notice, that the surgeon should not introduce his hand into the abdominal cavity, unless he be wearing rubber gloves which have been boiled—a dogmatic statement on a subject over which there has been much discussion. A good book well worthy of a prolonged perusal.

Lectures on Diseases of Children. By Robert Hutchison M.D., F.R.C.P. pp. xii and 338. (Edward Arnold). 8s. 6d. net.

We are very pleased to see that these lectures have been published in book form; first delivered at the London Hospital, they were afterwards published in the *Clinical Journal*, where they gave much satisfaction to many readers. Eminently practical in their teaching, and written in a very readable form, they bear the stamp of wide clinical experience. It is a melancholy fact that the average man is launched into practice with but a very meagre knowledge of children's diseases, though a very large proportion of his patients will be under ten years of age: his ideas on treatment are confined to the administration of gray powders and a mustard bath; while the mother or nurse is far more likely than he to know the ages at which the child should pass the "milestones of life"—which Dr. Hutchison describes, such as "holding up his head," "sitting up," "walking," "talking," and so on. The first chapter on examination of children is

full of useful advice: we are told always to auscultate before we percuss, so as to delay, if possible, the crying of the infant; that a "cracked-pot sound" can often be normally elicited if the child be crying, as the air is driven straight out of the mouth from the lung owing to the elasticity of a child's chest. We are reminded that the cardiac second sound is louder than the first in all cases, and that Babinski's sign is normal till the child begins to walk. The best chapters are those on Artificial Feeding and the treatment of Diarrhœa and Vomiting, most excellent simple rules are laid down, which we know have proved most trustworthy in other hands besides the author's. Loss of weight is shown to be the most important physical sign in a child suffering from gastro-intestinal disorders, and vomiting should be treated by washing out the stomach. Dr. Hutchison points out that clinical experience is always evidenced by a knowledge of the ages at which certain diseases occur. Acute rheumatism and infantile paralysis are unknown at less than one year, whereas posterior basal meningitis is commonest at that age, and rickets gives no evidence of its presence at less than six months. Drugs, again, are very well treated; children take Belladonna, Chloral and Bismuth very easily, the last in ten-grain doses even for an infant. Most excellent rules are given for the administration of opium, as for instance, that a child should never be awakened from sleep for its administration. Some very good photographs illustrate the book, and will help in fixing *the facies* in the mind, especially those in the chapter on Mental Deficiency. Dr. Hutchison says in his preface that he does not intend to compete with the many excellent text-books on Children's Diseases, but we feel sure no student should be without this book, as, unable to spare time for the larger treatises, he will here learn many things which otherwise practice alone in after-life will teach him.

Pass List.

University of Durham, October, 1904.

DEGREE OF DOCTOR OF MEDICINE FOR PRACTITIONERS OF FIFTEEN YEARS' STANDING.

T. Slater Jones, F. Kay Holman, H. Ellis Rowell.

Second Conjoint Examination, October, 1904.

Messrs. T. H. Edey, R. B. Dawson, M. D. Price, J. W. Featherstone, E. A. Collins, F. Morres, J. K. A. Helm, A. V. Ledger.

First Conjoint Examination.

PART I.—CHEMISTRY.—E. L. Brown, R. A. Glindon, H. V. Sharp.

PART II.—PHARMACY.—J. Cook, S. M. Wells.

PART III.—ELEMENTARY BIOLOGY.—F. H. Hollingsworth, M. J. Marks, F. J. Wheeler.

Sport.

FOOTBALL FIXTURES.

Saturday, November 5th.
G.H.R.F.C., I., v. Rosslyn Park, home.
II., v. African Banks, away.
III., v. Kensington III., away.
G.H.A.F.C., I., v. Ewell, home.
II., v. Ewell II., away.

Wednesday, November 9th.
Surrey v. Middlesex at Honor Oak Park.
G.H.A.F.C. II., v. Townley Park "A," home.

Saturday, November 12th.
G.H.R.F.C., I., v. Streatham, home.
II., v. Streatham II., away.
III., v. Lennox III., away.
G.H.A.F.C., I., v. Old Reptonians, home.
II., v. Surbiton Hill II., away.

Tuesday, November 15th.
G.H.R.F.C., I., v. Epsom College, away.

Wednesday, November 16th.
G.H.R.F.C., II., v. St. Bart.'s "A," home.

Saturday, November 19th.
G.H.R.F.C., I., v. Old Merchant Taylors, home.
II., v. Civil Service II., away.
III., v. Ealing II., away.
G.H.A.F.C., I., v. Surbiton Hill, home.
II., v. Surbiton Hill II., away.

Rugby Football.

GUY'S v. LENNOX.

This game was played at Honor Oak Park on October 8th, and resulted in an easy win for us. After the kick off we attacked strongly, our forwards heeling out the ball well. From a cross-kick, F. Alcock picked the ball up smartly and scored a try, no goal resulted. After J. P. Jones and Digby had put in some good kicks, our forwards rushed the ball down the ground, and Pinching scored; Alcock failed at the kick. Half-time was called with Guy's 2 tries.

After the kick-off, Lennox attacked, but good collaring and kicking by the three-quarters soon gave us the chance to attack again, and, after a good rush, J. P. Jones scored, no goal resulted again. The forwards were dribbling very well indeed, and at times heeled smartly, Louisson got the ball away from the scrum to Willan, who transferred to Digby, and the latter scored a beautiful try under the posts, Willan converting. After some even play, no side was called with Guy's 1 goal and 3 tries (14 points); Lennox, nil.

It is necessary for the Rugby football players to put more enthusiasm into their work, and more training. We shall not get the Cup back again unless a great deal more keenness is shown. We have had two severe defeats already, one from Catford Bridge, and the other from Cambridge, let us try not to lose any more games. There

are many new good players up, and it is to be hoped that all those who do not get into the first fifteen will play for the second, for there are reports that some men are playing for outside teams. These men should show more *esprit de corps*, and remember that it is better to play for Guy's second than any other team's first. It is only in this spirit that we can get the Cup back again.

GUY'S v. CATFORD BRIDGE.

This match was played at Honor Oak Park on October 15th, in fine weather. Catford Bridge went off with a rush and were soon attacking; they got the ball out to W. Balkwell, but he was well collared by J. P. Jones. After several attempts to cross the line, Balkwell got over in the corner; no goal resulted. After the re-start, Alcock made a good run down the line, but could not score. Catford attacked again, and T. J. Balkwell scored in good position. At half-time the score was Catford Bridge, 2 tries; Guy's, nil.

In the second spell Guy's had a little more of the game, but the whole side was playing badly. The ball never came out properly from the scrums, and the three-quarters, with the exception of Jones, failed to collar their men. No score resulted in this half. The game ended with Catford, 2 tries (6 points); Guy's, nil.

GUY'S 3RD XV. v. EALING 2ND XV.

Played at Honor Oak Park on Saturday, October 26th. Guy's came out easy winners by 8 goals, 7 tries (61 points), to 1 try (3 points). Tries were obtained by Adams (5), Lloyd (3), Whelon (2), Smith, Edsall, Oram, Hind and Cockram (1 each). The tries were converted by Harvey (6), Whelon and Adams (1 each). Team :—

GUY'S.—E. Penny (back); M. M. Adams, R. Edsall, R. G. Oram and A. Smith (three-quarter backs); C. E. Whelon and T. R. Harvey (half-backs); L. Lloyd, S. Cockrem, G. Hind, P. S. Mills, H. J. Clarke, M. Munden, C. H. Peall and G. Searle (forwards).

Association Football.

GUY'S v. THE CASUALS.

This match, which took place at Honor Oak on Wednesday, November 2nd, resulted in a win for Guy's by 3 goals to 2. The score just about represents the game, although on one or two occasions we might have increased our total, Piper having bad luck in hitting the post with a low cross drive. We took a long time settling down, and for the first 15–20 minutes it looked any odds on our being beaten. The Casuals started, and after a few minutes' play scored, and for the next twenty minutes did most of the pressing, the defence seeming disorganised. We gradually settled down, however, some good runs taking place on the right, and from a centre by Wragg, the opposing full-back put through his own goal, thus equalising matters. The play was now even up to half-time, but, from a rush by the Casuals, our goal-keeper in trying to clear, miskicked, and the sides crossed over with the Casuals leading by 2—1.

Play in the second half was largely in our favour, and save on one or two occasions, was entirely confined to our opponents' territory. Despite this, however, there was a lack of finish among the forwards, and it was not until the last ten minutes that, from a rush, Barnett put the scores level. Shortly afterwards the same player headed a third goal, after the goal-keeper had fisted out a good shot from Denning. No further scoring took place, although Litchfield headed just over the bar from a corner. Both the outsides were good, and the defence, after it had settled down, was very sound.

Change of Address.

Dr. W. A. Aikin, from 14, Thurloe Square, S.W., to 66, Bedford Gardens, Kensington, W.

Dr. E. Bigg, from the Dispensary, York, to The Gables, Cranleigh, Surrey.

Dr. P. P. Cole, from Guy's Hospital, to St. John's Hospital, Lewisham.

Dr. Stanley Hodgson, from 201, Brixton Hill, to the Crescent, Salford, Manchester.

Dr. W. P. Le Feuvre, from Raylton, Bulawayo, to P.O. Box 150, Bulawayo, Rhodesia, South Africa.

Mr. Leonard Myer, L.D.S., from 157, Sutherland Avenue, W., to 76, Wimpole Street, W.

Dr. A. E. Poolman, from the Berkeley Hotel, London, to 10, Weymouth Street, Portland Place, W.

Major J. V. Salvage, R.A.M.C., from Westfield Cottage, Thruxton, to 1, The Avenue, Andover.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Calendar.

November, 1904.

Sat. 5.—Messrs. Symonds and Steward's take-in; Drs C. Ponder and W. H. Robinson: Cl., H. M. M. Woodward.
Physical Society's meeting at 8 p.m. Pathological meeting. President: N. I. Spriggs, M.B., B.S.

Mon. 7—Cambridge 1st, 2nd, and 3rd M.B. Schedules to be brought to Medical School Office for signature.

Thur. 10.—Messrs. Lucas and Lane's take-in; Drs. E. Alban and P. S. Mills; Cl., F. Alcock.
G.H.C.U., Address by Col. Herbert Everitt.

Thur. 17.—Messrs. Golding-Bird and Dunn's take-in; Drs. A. W. Berry and H. F. Vandermin; Cl., J. M. Barrionuevo.

Births.

BROWNFIELD.—On October 30th, at the Old College, Petersfield, Hants, the wife of H. M. Brownfield, M.R.C.S., L.R.C.P., of a daughter.

WILLAN.—On October 24th, at 39, Crown Road, Milton, Sittingbourne, the wife of George T. Willan, B.A., M.R.C.S., L.R.C.P., of a daughter.

Death.

SARGOOD.—On October 22nd, at Guy's Hospital, George F. Sargood, L.D.S., aged 25.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 431.] NOVEMBER 19, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	473–475
A Case of Chronic Jaundice. Clinical lecture by Dr. W. Hale White	476–481
Notices	481–482
J. H. Bryant, Esq., M.D., F.R.C.P., in a Bunker	483
Impaction of Decayed Tooth in the Trachea	484
Papers by Guy's Men	484
Notes from Skin Outers	485
Guy's Hospital Debating Society	485
Appointments	485
Reviews	486–487
Pass List	487
Correspondence	487–488
Cavillings	488–489
Sport	489–491
From the Gazette's Special Pathologist ...	491
Change of Address	491

Passim.

THERE may be a few choicer spirits who can find some comfort even in the dark November days which have lately enshrouded us. We would that we could join their number and endeavour in these columns to add somewhat to the gaiety of nations, but it is a task beyond our power. To us the gloom would seem to be more than atmospheric. It has eaten its way into the very minds of our till now staunchest supporters, and journalistically we stagnate. Will all who love their GAZETTE with an unselfish love take note of this cry from Macedonia, and help us?

AT present there are many knotty problems to perplex the mind of the Guy's football men, but perhaps the most weighty matter, and one which concerns not only Guy's, but all the large metropolitan hospitals, is the question of the extension of the five years' limit. We believe we are right in saying that the proposition to alter the existing regulation emanated from Guy's, and since we are no longer holders of the Cup, there can be no impropriety in our thus taking the initiative. But the proposition presents considerable difficulties, and opinions are much divided even among the experts. It is urged by some, that as matters now stand, no hospital team is truly representative of the best that that hospital can produce. A good man is, under the present regulations, shelved, in so far as his hospital is concerned, at the expiration of the appointed five years' term and compelled to expend his energy in an outside club, while his old post is filled possibly by some raw hand, who, owing to the scarcity of reserves, is barely worth his place in the team. It is scarcely in accordance with the ever-growing importance of Inter-Hospital football that a team should be liable to contain these raw recruits while yet purporting to be representative. On the other hand, there are those who argue that in fairness

to the junior man the limit should remain unextended, and that each hospital must run the risk of temporary discomfiture in the field, that the honor of representation may fall equally to the lot of those among the successive batches of players who are in any way worthy of a place in the first team.

A DEFINITE decision has yet to be arrived at, and a special Inter-Hospital Committee has been appointed with this object in view. In the meantime several representative men of other hospitals express themselves in favour of an extension, and it certainly would seem that even the most powerful team at least would lose nothing were this innovation to be brought about. It is a matter which calls for a thorough discussion, and all will await events with considerable interest.

ANOTHER question, and one which concerns Guy's alone, is the general lack of interest evinced by the senior men in Hospital football. The teams have good grounds for complaint in this matter, and it is specially unfortunate that interest should thus slack off when so great an effort has been made by the Clubs' Union Committee to make a special feature of the "gate." A few years ago the same complaint was made by the football authorities: namely, that the Residents and senior men generally, did not seem to mind what happened to Guy's football, and now history is repeating itself. One would have thought that, under the circumstances, a special effort might be made to encourage the teams and to help the Clubs' Union by making use of the new stand, the charge for admission to which is not ruinous. It is not too much to say that it is part of the duty of the representative men of the Hospital to encourage the teams by their presence on the touch-line, and it would be better if this were more generally recognized.

CONSIDERABLE discussion has been aroused over the circular sent out by the temporary committee of the prospective Centurions Dinner Club, and in our opinion a great deal of the criticism which has been levelled at the heads of the aforesaid committee is both ill-advised and scarcely generous. It may be open to question whether it was wise to publish a printed list of names and thus inevitably to be guilty of omissions of an obvious and unfortunate nature, but the fact remains that the six members of the committee are the first among the Residents for the past ten years or thereabouts who have stirred hand or foot to bring about some form of annual reunion of Guy's men, and they at least deserve some thanks for making the attempt. As regards the more obvious omissions in the list of names, we are sure that the committee were the first to recognise and regret these when their unfortunate list appeared.

IT will be a thousand pities if this movement fails for lack of support. It is useless to deny that there are flaws in the arrangements as they now stand, but that there should be these is inevitable seeing that there has been no similar club formed of late years that might have included the more senior men named on the present list. The question as to whether the scheme is too comprehensive or is not comprehensive enough does not concern us at present, the main object to be achieved at present being the successful convening of a full assembly at the first dinner on December 14th. This is what the provisional committee are aiming at, and it is to be hoped that they will meet with the support of all who wish to see a dinner club of some kind formed, at which they can, year by year, meet their old friends. It will be better if all adverse criticisms are reserved till the date in question, when the provisional committee intend to stand down and the meeting can discuss all plans for the future, at the same time electing a permanent committee. In the

meantime we shall welcome suggestions, with regard to the future of the proposed club, in these columns.

We have been asked to announce that a concert of the Nurses' Choral Society and Students' Glee Club has been fixed to take place on Tuesday, December 13th, in the Court Room. The programme will be a miscellaneous one.

Most of us are just awaking to the fact that Christmas will be upon us in another month, and the usual bustle of preparation is beginning to evince itself in certain quarters. The wily and annual nigger is preparing to astonish the wards, and there is a desperate effort on foot to secure new songs and to decently disguise old jokes. The musical arrangements are in the most competent hands possible, and we feel sure that this year's show will at least equal previous records. Christmas Day falls this year on the first day of the week, but there need be no fears that the dull calm of a Hospital Sunday will be in any way enlivened by the possibly welcome nigger. Monday, Dec. 26, is the day fixed upon for the latter's delirious advent. The histrionic talent also amongst the Residents is, we believe, again straining at the leash, but we can speak with no authority at present. We can, however, hold out solid grounds for hope to all those who love their house-surgeons and house-physicians that old customs will not be departed from, and that the Guy's Residents will once more astonish an expectant Hospital.

The Oxford and Cambridge Dinner, which was held at the Holborn Restaurant on November 9th, with Dr. Newton Pitt in the chair, was a most successful occasion, and gave the greatest satisfaction to all concerned. We have no doubt that this will now become an annual function.

We have been authorised to state that the new Squash Court, that is to be, is engaging the attention of the Governors, and that these latter have generously offered to defray the cost of its erection. It is fully recognised that the temporary absence of the court, both has been, and is still a serious drawback for those dwelling in the College who aim at keeping fit, and have little time for Honor Oak and for the more popular forms of sport. It was impossible, however, with the extensive building and alteration necessitated in the neighbourhood of the Library to preserve the old Squash Court or to erect a temporary substitute for the same. The new court will be built at the earliest possible date, and it may be as well to point out to all the more junior men that it is not the monopoly of the Residents, who only have prior claim during certain hours, but that the court is open to all at other times. There have been some slight misunderstandings on this point in the past, and before the new court arrives, it is as well for everyone that they should know how matters stand.

Our correspondent, in his letter on "Historical Guy's," voices a feeling which we know to be prevalent amongst those who are interested in the past of this institution. We would point out, however, that we have already announced the intention of the authorities to devote a corner of the new Museum to relics and curios of historical interest to Guy's men. As regards the portraits, the absence of which "P. R." deplores, the Gazette Committee has arranged that the first of a series of pictures of Guy's celebrities, shall appear in the Christmas number of the Gazette, and shall consist of a portrait of Thomas Guy. Of the Washbourn Memorial Committee we are not at present in a position to speak, but hope to be able to furnish our readers with information on this subject in our next issue.

A Case of Chronic Jaundice.

CLINICAL LECTURE BY DR. W. HALE WHITE.

October 8th, 1904.

GENTLEMEN,—The woman whom you see before you is 39 years old, and she came into the hospital on July 22nd this year, for jaundice. She told us that two years ago she had an attack of congestion of the liver, but we were not able to make out whether it was an attack of catarrhal jaundice. She said her present trouble has lasted twelve months; treatment has given her no relief; she has only once had pain, and that was on the left side, and so was probably unconnected with the jaundice. She has had no rigors nor vomiting, and she has lost a little flesh. When she came in her body was fairly well nourished. Everywhere she was very deeply jaundiced; the sclerotics, as well as the skin, being affected. We found the liver considerably enlarged, for it reached three inches below the ribs; it was quite a uniform enlargement, smooth and regular, with an even edge. In fact, the feel of it suggested that it was over-distended with bile; otherwise we found nothing wrong in either abdomen or chest. The urine, as you might expect, was full of bile. The rectum appeared quite healthy, and the stools were white. Nowhere in the body could we find a place that suggested itself as the seat for a primary malignant growth.

The subsequent history is very quickly summed up; between July and now she has gradually got better, and has gained in weight. Last time she was weighed her weight was 3lbs. more than on the previous occasion, and she is weighed weekly. Her jaundice is very much less, and in fact you can scarcely see it at all, in her hands, for instance. The only incident in the course of the uniform improvement was, that about the middle of August she suffered from two decayed teeth on the left side, they were taken out, and the subsequent bleeding was so furious that, notwithstanding all we could do, plugging the cavities with adrenalin, for example, we could not check it. Then, after the gums had been oozing 48 hours, Sir Alfred Fripp saw the patient, an anæsthetic was given, the edges of the gum were sewn over the apertures, and so the bleeding was checked. I only mention that to remind you of what you all know, how very liable people with jaundice are to bleed furiously. She nearly lost her life from the extraction of two teeth. Three years ago a woman was admitted into the hospital for deep jaundice, and when she had only been in a few hours she began to bleed copiously from the uterus. The obstetric physician was called in, but could not stop the bleeding, and she died. When she came in she was covered in various parts of her body with large subcutaneous hæmorrhages of the size of the palm of the hand. Why those who are jaundiced bleed so seriously, we do not know.

In seeking to find what was the matter with our present patient, obviously the fact to seize upon was, that she was suffering from chronic jaundice; we can clearly call it chronic as she has had it more than twelve months. So we first had to go over what could possibly be the causes of chronic jaundice. Now, you know the causes of jaundice are very numerous; there is a terrible list in the text-books, but in this country the common causes of *chronic* jaundice, I mean jaundice which lasts a long while, are very few. They are malignant disease, cirrhosis of the liver, impacted gall-stones and chronic pancreatitis. Other rarer causes are given in your text-books, but they are so infrequent that you ought not to diagnose them until you have confidently made up your mind that the patient is not suffering from any of the four conditions I have mentioned. Other rarer causes which the books give are, for instance, various bands and cicatrizations in connection with old peritonitis, or old gastric or duodenal ulcer. But they must be extremely rare as a cause of jaundice, and although jaundice is very common, I have not come across a case due to gastric or duodenal ulcer; still, it may occur. The books also tell you that various innocent tumours pressing on the duct will cause jaundice, such as a renal tumour, ovarian tumour, aneurysm, fæces, and so on. But these are very infrequent causes of jaundice, and to show you how rare, I have only twice, as far as I can recollect, seen jaundice due to these causes. Once an aneurysm pressed on the duct and caused jaundice, and in another it was caused by a kidney pressing on the duct. The books tell you that parasites may crawl up the duct and cause it. I always notice in correcting examination papers that the candidate who has not seen many patients, but has read diligently, usually mentions parasites creeping up the common bile duct as the first cause of jaundice; but it is so rare that you may dismiss it from your minds. Another cause of chronic jaundice is undoubtedly heart disease, but that does not cause any difficulty in

diagnosis, because the heart disease is so obvious that you cannot miss it. The over-secretion of mucus in the duct never, so far as I know, lasts as long as it did in this patient—a whole year, and therefore hardly comes into the category of very chronic jaundice.

So in her case we had at first to think of only the four things I mentioned a minute or two ago. Naturally we first asked, Has this woman got malignant disease? In passing, I may remind you that the reason why people with malignant disease have jaundice is not because of the malignant disease in the liver, but because secondary to the malignant disease of the liver the glands in the portal fissure become affected with growth, they press upon the bile duct, and consequently the patient has obstructive jaundice. Many of you have frequently examined this woman, and we were glad to be able to decide, when she first came in, that she had not got malignant disease. In the first place, her liver was three inches below her ribs, and yet it was perfectly uniform and smooth, with a smooth edge. Then, though she had been ill a year, her wasting was only slight, and nowhere could we find any primary seat of malignant disease, though we examined the abdomen, the rectum, and the pelvis most thoroughly. Some might have been inclined to suggest that she had malignant disease with the primary seat in the liver. We were quickly able to dismiss that. Primary malignant disease in the liver is very uncommon. Here we only average one such case in two years. I went through twenty years post-mortem reports and found ten cases in that time. Again, we only get one case of primary growth in the liver to twenty cases in which growth is secondary. Still, of course, the mere rarity of the disease is not a final argument against any patient suffering from it. There were other stronger reasons which made it certain she had not primary malignant disease of the liver, and they were two. In the first place, it is a very rapid disease. No case we have had here has survived four months; frequently the duration has only been two months. This woman had been ill twelve months when she came in. Then, as you would expect from the disease being so rapid, these patients are frequently not jaundiced. When the disease is primary in the liver there is not time before the patient dies for the glands in the transverse fissure to become sufficiently enlarged with secondary deposits for them to press on the bile duct, and so cause jaundice.

Next we turn to cirrhosis among the four common causes. Here, again, feeling the liver was invaluable, because its surface and edge were perfectly smooth, and it was not unduly hard. It was just of the consistency of normal liver. If the case had been one of cirrhosis the liver would probably have been uneven, from a just tangible unevenness to the hob-nail condition. Then cirrhosis never gives very deep jaundice; it is usually comparatively slight. And please do not go away with the impression that this woman was of her present colour when she first came in; she was of a much darker tint. As you would expect from the slight jaundice, the stools in cirrhosis are not typically clay-coloured, as they were in this patient. Then, too, she had no vomiting, no ascites, no swelling of the feet, and, in fact, none of the other symptoms of cirrhosis. You will notice that I have arrived at the fact that she has not got cirrhosis without questioning about alcohol. And it is always well that you should try to do so, because patients who have taken alcohol freely will frequently deny it, and put you off the scent.

With regard to impacted gall-stones. She has no history of previous attacks of gall-stones; still, it might have been that the first gall-stone that gave symptoms had become impacted in the common duct. But when gall-stones become impacted in the common duct, the impaction occurs just where the duct lies obliquely in the wall of the duodenum, for, as you know, the orifice into the duodenum is the narrowest part of the duct. And a stone large enough to be impacted there usually causes a good deal of pain. Not only that, but during some period of the twelve months she would probably have had rigors. Another argument is that, even supposing a stone had been impacted for twelve months, she had no signs of cholangitis. It would be in the highest degree exceptional for a stone to be impacted in the duct for twelve months and for there to be no inflammation in the duct behind. That inflammation, which is always bacterial, may, as you know, be an inflammation without any obvious exudation of pus, and it is often accompanied by pyrexia. Or the ducts may become full of pus, so that at the autopsy you find tubes of pus running through the liver. Again, there may be, secondary to the inflammation round the stone, local pyæmic abscess in the liver. Or, lastly, there may be just one large abscess around the stone. But it is hardly likely that a gall-stone would be impacted for a year without

any of these complications following. Had she had a gall-stone, which she passed, for usually the gall-stone lying obliquely in the wall of the duodenum, ulcerates into the duodenum, she would have comparatively quickly got well, but she has been in here three months, and the jaundice has only slowly subsided.

So that by a process of exclusion we come to the opinion that this woman probably had chronic pancreatitis.

Naturally you want to know what chronic pancreatitis is. If you include under the term the hard pancreas that follows upon long-standing venous congestion, such as you meet with in heart disease, that is the commonest form of chronic pancreatitis. Out of six thousand seven hundred and eight consecutive autopsies the pancreas was described as cirrhotic, congested, or hard in twenty-six, and in twenty-three out of the twenty-six there was some severe cause of increased backward venous pressure, such as heart disease or emphysema. In two of the remaining cases there was cirrhosis of the liver, which again you see might lead to increased pressure in the portal vein. When people speak of chronic pancreatitis they do not usually mean the chronic induration of the gland that follows upon long-standing backward venous pressure from disease of the heart or cirrhosis of the liver. Nor do they generally include the atrophic pancreas which is associated with diabetes. The word "chronic pancreatitis" is usually applied to a condition in which the pancreas is much enlarged by chronic inflammation, and that enlargement produces jaundice by pressing upon the common bile duct. I think I shall be able to show you presently that we do not know much about the post-mortem appearances of chronic pancreatitis, because it is very rarely fatal. But when the abdomen is opened, as it often is by the surgeon for this condition, the gland can be felt and seen to be large and hard, large enough to cause, by its pressure, obstructive jaundice. The absence of port-mortem records of this condition makes the ætiology rather difficult to trace. But it is certain that chronic pancreatitis may follow the presence of a stone in the ampulla of Vater, which is the dilatation of the common bile duct above the opening into the duodenum. Indeed, it was in that way that chronic pancreatitis was discovered. Several surgeons opened abdomens for impacted gall-stone, and when they put their hand in the abdomen they felt the pancreas to be hard and enlarged, and so they believed it to be affected by carcinoma. But to the surprise of the operator some of the patients got well. Many of the early cases of chronic pancreatitis were thought by the surgeon to be instances of carcinoma of the head of the pancreas associated with gall-stones, but as the patients got better surgeons learned that there was a chronic induration of the pancreas associated with the presence of gall-stones in the duct, which is not surprising, because the duct is lying behind the head of the pancreas.

Among other causes of chronic pancreatitis it is supposed that sometimes inflammation spreads up the lumen of the pancreatic duct from the duodenum, and therefore chronic pancreatitis is supposed to follow duodenal catarrh. It has been known to follow typhoid, and the typhoid bacillus has been shewn to be a cause of it; and although you can find many other causes given in books, such as syphilis, endarteritis and tubercle, they chiefly exist in the minds of the writers, and are of no practical importance at all, as far as I know.

Usually when there is chronic pancreatitis there are some peritoneal adhesions round about the pancreas. I mention that, because importance has been attributed to them as a cause of the jaundice.

The next question is, Do the described symptoms of chronic pancreatitis fit in with the symptoms which this woman had? The most constant symptom is deep jaundice, and she certainly had that; and with this deep jaundice there are all the associated symptoms of jaundice; itching of the skin, slow pulse, bile in the urine, and the clay-coloured stools. If you are in any doubt about the symptoms, remember that until chronic pancreatitis was described as a separate disease, the cases were nearly always thought to be malignant disease of the pancreas.

Now, inasmuch as the chronic pancreatitis causes the jaundice, mechanically, by blocking the common duct as it comes into the duodenum, you get, as a second group of symptoms of chronic pancreatitis, an uniformly enlarged liver, such as this woman had, and a distended gall-bladder. Perhaps it is worth while to point out to you in passing, that a distended gall bladder nearly always means that the cause of the obstruction to the flow of bile is not a gall-stone. If a gall-stone is blocking the common duct, the presumption is, that at some time there have been gall-stones in the gall-bladder, and they, by their presence, often set up chronic inflammation of the gall bladder, so that the walls of the gall-bladder thicken, and its cavity becomes lessened. The contents of the biliary passages and gall-bladder behind the obstruction in a chronic case always surprise beginners,

because instead of bile they usually find clear mucus. The reason is that the bile is secreted under such a low pressure that when obstruction occurs in the duct the pressure in the duct is such that no more bile is secreted into the duct, and that already there becomes absorbed quickly. The duct continues to secrete its own mucus; so in the post-mortems on cases of obstructive jaundice we find colourless mucus in the ducts and in the gall-bladder. However, to return to chronic pancreatitis, the symptons I have already enumerated are by far the most important symptoms, and many patients have very few others. Among the other symptoms which are described and occur is wasting. Our patient wasted a little. Sometimes the patients complain of some pain in the region of the head of the pancreas, and they frequently have some tenderness there. Sometimes they are sick, but often they are not.

Returning to the stools, I ought to mention that, as you would expect, very often there is fat in the stools, because the pancreatic secretion cannot reach the duodenum, and there are undigested muscle fibres found in these clay-coloured stools. Lastly, you will find it described that an enlarged pancreas may be detected during life. That is true, but it is often very unsatisfactory to try to detect an enlargement of the head of the pancreas clinically, because when its head is enlarged, that very enlargement causes jaundice, which, as we have seen, leads to a big swollen liver, so that the liver hangs over the head of the pancreas, and you cannot get at what you want to feel. Then, as the pancreas is deep in the abdomen, it is very difficult to be sure of what it is you are feeling; for instance, it may be a mass of enlarged malignant glands, or some other deep tumour in the abdomen. And, lastly, in a fat abdomen it would be almost impossible to get down upon the head of the pancreas. Beyond that, there is the fallacy that if the patient is very thin you may feel a pancreas which is of normal size. You will remember a case less than a year ago, that of a man who was under me, just before he died. He had hæmatemesis; before I saw him an anæsthetic had been given, and the house-physician told me that a mass of malignant disease had been felt in the abdomen. When I saw the patient he was evidently a dying man, and the abdomen was very rigid; naturally, as I had not the advantage of examining him under the anæsthetic, I accepted the opinion of those who did so, and they said he had a mass of malignant disease in his abdomen. After he was dead we found that there was no malignant disease in his abdomen. Clearly what had been felt under the anæsthetic was the normal head of the pancreas. The man had a huge gastric ulcer which destroyed the whole of the posterior wall of the stomach, and he died of inanition in association with this trouble.

I know an even more striking instance. Some years ago a woman admitted into Miriam ward died of uræmia a few hours after admission. We were examining her carefully, and we found, as we thought, a lump in the abdomen, and took it to be malignant growth. When the abdomen was opened in the post-mortem room I and the clinicals put our hands into the abdominal cavity and said, "There is the lump that we felt," but when the organs were taken out, what we felt was simply the hard head of the pancreas. She had granular kidney. So do not place too much reliance upon feeling the pancreas as diagnostic of chronic pancreatitis.

Also please remember, as I have already mentioned, there is often difficulty in feeling the gall-bladder. We have sometimes felt this woman's gall-bladder enlarged, sometimes not. One reason why the gall-bladder when enlarged is difficult to feel is that often the liver hangs over the gall-bladder. But the reason why it varies, apparently, from day to day is, because an enlarged gall-bladder is a soft tumour with nothing hard behind it, only the ordinary abdominal contents, so that there is nothing to press against, and this may sometimes account for the inability to feel it.

Having found out that our patient had chronic pancreatitis, naturally our next question was as to what to do for her. And when you have that to consider in any disease, you of course want to know what is the likelihood that the patient will die from the disease. Some of you had the impression that patients with chronic pancreatitis always die unless an operation is performed. Now, that is *not* so. In order to try and make out whether that was so, I have been through our post-mortem records for forty years. If a patient died of chronic pancreatitis it would be quite certain that if at the post-mortem examination the disease was not recognised as chronic pancreatitis, the enlargement of the head of the pancreas would have been mistaken for malignant disease. Therefore I went through all our cases of malignant disease of the pancreas, and of course I excluded all those in which there were secondary deposits, because they could not be chronic pancreatitis; the existence of secondary deposits put that out of court. And I found that in forty years we had only had ten cases that were

thought to be malignant disease of the pancreas, and in which no secondary deposits were found. With regard to these ten, in four the cause of the enlargement was undoubtedly malignant disease, for they were examined histologically; two others from the description were clearly malignant disease. Only four fatal cases therefore are left in forty years which could by any possibility be chronic pancreatitis. One almost certainly was, but in each of the other three there was some evidence they were not, so this we may say, that fatal chronic pancreatitis is excessively rare.

I can point to some clinical cases which shew that this disease is not if left to itself fatal. One I have often quoted, because it was the first which opened my eyes to the subject, that of a man who was deeply jaundiced and wasted and had abdominal pain. Two doctors who saw him told him he had malignant disease. I saw him and told him the same, and that his case was hopeless. But he practically insisted on having his abdomen opened, because he said we might be wrong, and that something might be found which could be relieved. Mr. Edmund Owen accordingly opened the abdomen, and finding what he believed to be malignant disease of the head of the pancreas, shut it up again. The jaundice passed away, the patient gained in strength, and though the operation was done four years ago, he is up and about, and fat and well, going to his business every day. That was the first case which suggested to me that cases of chronic pancreatitis can get well if left alone.

Before coming to the lecture I jotted down notes of two other cases. One was that of a woman of about 40 years of age, whom I saw in the early part of 1903. She had had jaundice for ten months; her motions were clay-coloured, she was wasting, her liver was large, so was her gall-bladder, and she was tender over the pancreas. She had been told that if she was not better in a couple of months it was a case for surgery. Bearing in mind the case I have related to you, I dissented from that view, and told her she should wait at least a year. She came to see me exactly a year after I had given that opinion, and then she had gained eight pounds in weight, had the merest trace of jaundice, her motions were of normal colour, the bile had disappeared from the urine, and she was almost well.

Quite recently a case which has interested me very much turned up, showing how these people get well. It was the case of a man æt. about 35, who had catarrhal jaundice eleven years ago, and when I saw him he had been ill seventeen days with the same thing. It had been quite impossible for him to go for a holiday, so he had kept about his work. He had taken little, which was not surprising, because anorexia in catarrhal jaundice is very severe. He had lost considerably in weight, the liver was uniformly enlarged, the gall-bladder distended. He had some pain and tenderness over the head of the pancreas, and he was almost certainly a case of catarrhal jaundice in which the catarrh had set up chronic pancreatitis. It was evidently severe, as he had a temperature of 101° or 102° every evening for some time and I suspected that there might be pus: but the blood-count was normal. Slowly his jaundice has gone, bile has reappeared in the motions, it has disappeared from the urine, he has gained strength, and is now getting well. (I saw him November 4th, his jaundice had gone and he was well).

Of course you can help these patients a great deal, but they will usually get well if left to themselves. Your best plan is to put them to bed and rest them. It is also good to diet them. If you make them abstain from fatty foods they do not suffer from the disagreeableness of a quantity of undigested fat, which in itself produces nausea, besides making the motions offensive. And they are benefited by the bowels being regularly opened by a mercurial purge, such as a grain of calomel with extract of euonymin. And, as the last case I related to you shews, they do very badly if they keep up and about.

I have referred two or three times to the question of operation. Originally these cases were mistaken for malignant disease of the pancreas, and the gall-bladder was drained in the hope that this might relieve the distressing symptoms of jaundice. It was found that the patients got well, and it was concluded that this draining did some good, though no one was able to suggest how it did so. I think I have given you evidence to shew that your cases may do just as well if you put them to bed, diet them properly, keep the bowels open, and so save them from a very disagreeable operation, because having the gall-bladder drained is a disagreeable operation. Of course, if you saw a patient whom you thought was dying, instead of the treatment I have recommended you could always fall back upon trying drainage of the gall-bladder. But in the vast majority of cases of chronic pancreatitis it is unnecessary, and I think it will gradually pass out of use.

There is another point which I have kept to the last, because it is doubtful. We were very interested in some crystals from this woman's urine. Inasmuch as the subject of disease of the pancreas is in its infancy, people are seeking everywhere for a new sign which will enable us to diagnose these cases easily; and the ingenious notion occurred to Dr. Cammidge that he might find something in the urine that would help us. His line of argument was this: fat necrosis is common in disease of the pancreas; now when that occurs, the fat is split up into a fatty acid which is found in crystals in fat necrosis and glycerine, which he supposes is passed into the blood and might be detected in the urine. I need not weary you with the details of how to get at the question of the glycerine. Here is a reprint of the Arris and Gale Lecture which Dr. Cammidge gave, and it is taken from the *Lancet* of March 19th, 1904. Practically, the whole argument depends on the assumption that glycerine will be passed into the blood and thence into the urine as a result of the pancreatic disease. The urine is boiled with a mineral acid and then treated with phenyl hydrazin and characteristic crystals form which can be seen under the microscope.

He found in cases of pancreatic disease the reaction (which he called reaction A) was interfered with in inflammation of the pancreas, if he previously treated the urine with perchloride of mercury. And so he gets two tests; one in which the urine is first treated with perchloride of mercury, and one in which it is not. And if the formation of the crystals is interfered with by preliminary treatment of the urine with perchloride of mercury, he assumes that chronic pancreatitis is present. If the test is not interfered with by the treatment with perchloride of mercury he assumes that the disease of the pancreas is not pancreatitis of a chronic kind. For further details you must read the original paper.

In the first place, however, this work has been severely criticised from a chemical point of view. And, in the next place, Dr. W. H. Willcox has written to the *Lancet* for July 23rd, 1904, severely criticising it from the clinical point of view. His words are: "That the production of characteristic yellow crystals in a urine after hydrolysis by boiling with hydrochloric acid can in no sense be used as a specific test for any special pathological condition, since such crystals are constantly obtained from normal urine."

Mr. Allen, who is my clinical assistant, obtained crystals from the urine of my patient, but also very similar crystals from his own urine. The question of whether this test is of any practical use must be considered to be at present entirely in the balance, and it is only by collections of cases by independent observers that we can know if it has any value.

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Wednesdays, November 23rd and 30th, 1.30 p.m., Clinical Surgery, by Mr. Golding-Bird.

Saturdays, November 19th and 26th, and December 3rd, 1 p.m., Clinical Medicine, by Dr. Taylor.

Monday, November 21st, 1.15 p.m., Lecture by Mr. G. B. Smith.

Monday, November 28th, 1.15 p.m., Lecture by Mr. Higgens.

Notices.

UNIVERSITY OF OXFORD, MICHAELMAS TERM, 1904.

EXAMINATIONS FOR THE DEGREE OF BACHELOR OF MEDICINE.

The Examinations for the Degree of Bachelor of Medicine will commence in the Examination Schools on Thursday, December 8th, 1904, and will be held in accordance with the following time table:—

FIRST EXAMINATION.

Thursday, December 8th.—Examination Schools.—9.30 a.m., Human Anatomy; 2 p.m., Physiology.

Friday, December 9th.—Examination Schools.—9.30 a.m., Materia Medica; 2 p.m., Organic Chemistry.

Saturday, December 10th.—Department of Chemistry or Pharmacology, Museum.—9.30 a.m., Practical Examination in Materia Medica, and *viva voce*. Department of Chemistry, Museum.—2 p.m., Practical Examination in Organic Chemistry, and *viva voce*.

Monday, December 12th.—Department of Physiology, Museum.—10 a.m., Practical Examination in Physiology and Histology.

Tuesday, December 13th.—Department of Human Anatomy, Museum.—10 a.m., Practical Examination in Human Anatomy, and *viva voce*. Department of Physiology, Museum.—10 a.m., *Viva voce* Examination in Physiology.

SECOND EXAMINATION.

Thursday, December 8th.—Examination Schools.—9.30 a.m., Pathology; 2 p.m., Principles and Practice of Surgery.

Friday, December 9th.—Examination Schools.—9.30 a.m., Principles and Practice of Medicine; 2 p.m., Midwifery and Diseases of Women.

Saturday, December 10th.—Examination Schools.—9.30 a.m., Forensic Medicine and Hygiene. Medical Department, Museum.—2 p.m., Practical Examination in Pathology.

Monday, December 12th.—Medical Department, Museum.—9.30 a.m., *Viva voce* in Pathology; 10 a.m., Practical Examination in Forensic Medicine and Hygiene; 2 p.m., Practical Examination in Chemical and Microscopic methods of Medical Diagnosis.

Tuesday, December 13th.—Radcliffe Infirmary.—10 a.m. and 2 p.m., Clinical Examination in Medicine. Written reports of cases, and *viva voce* at bedside.

Thursday, December 15th.—Radcliffe Infirmary.—10 a.m. and 2 p.m., Clinical Examination in Surgery. Written reports of cases, and *viva voce* at bedside.

Friday, December 16th.—Radcliffe Infirmary.—9.30 a.m., Examination in Surgical Anatomy, the methods of operations, and instruments. Medical Department, Museum.—2 p.m., *Viva voce* in Medicine, Surgery and Midwifery.

The Secretary to the Boards of Faculties gives notice that the Names of Candidates, entered on forms issued for the purpose, must reach him at his office in the Old Clarendon Building, Broad Street, not later than 10.30 a.m. on Wednesday, November 23rd, accompanied in each case by the Certificates of instruction required to be presented before admission to Examination, and by a Certificate dated and signed by the proper officer of a College or Hall, or the Censor of Non-Collegiate Students to the effect that the Candidate's name is at that time on the books. The printed Forms of Entry, and all Forms of Certificates, can be had on application at the Secretary's office.

The Statutable Fee must be paid at the time of entering the name.

On payment of an *additional* fee of Two Guineas, any name not received by the above-mentioned time can be placed in a Supplementary List, and the Candidate be admitted to the Examination, provided that the form, fee, &c., reach the Secretary before noon on Friday, December 2nd.

C. LEUDESDORF,
Secretary to the Board of Faculties.

Clarendon Building, Broad Street, Oxford.
October 15th, 1904.

EXAMINING BOARD IN ENGLAND
BY THE
ROYAL COLLEGE OF PHYSICIANS OF LONDON
AND THE
ROYAL COLLEGE OF SURGEONS OF ENGLAND.

The following are the dates on which the Examinations will commence in the year 1905:—

FIRST EXAMINATION.

* *Chemistry.*—Tuesdays, January 3rd, March 28th, July 18th, September 26th.

Biology.—Tuesdays, January 3rd, March 28th, July 18th, September 26th.

Practical Pharmacy.—Wednesdays, January 4th, March 29th, July 19th, September 27th.

SECOND EXAMINATION.

Physiology.—Thursdays, January 5th, March 30th, June 29th, October 5th.

Anatomy.—Fridays, January 6th, March 31st, June 30th, October 6th.

THIRD OR FINAL EXAMINATION.

† *Medicine* (1st Paper).—Tuesdays, January 10th, April 4th, July 4th, October 10th.

Medicine (2nd Paper).—Wednesdays, January 11th, April 5th, July 5th, October 11th.

Midwifery.—Thursdays, January 12th, April 6th, July 6th, October 12th.

Surgery.—Fridays, January 13th, April 7th, July 7th, October 13th.

* The Examination in Practical Chemistry will be held on Fridays, January 6th, March 31st, July 21st, September 29th.

† Candidates who registered as Medical Students before the 1st January, 1892, are not required to sit for the First Paper in Medicine.

The First Examination (Part I. Chemistry and Part III. Elementary Biology) will be held in Manchester as well as in London provided there are at least ten Candidates in each subject. Candidates should state when sending in their applications whether they desire to be examined in Manchester or in London.

Candidates intending to present themselves for examination are required to give notice in writing to the Secretary of the Examining Board in England, Examination Hall, Victoria Embankment, London, W.C., *fourteen clear days before the day on which the examination commences*, transmitting at the same time the required certificates.

All candidates are required to produce certificates of age when entering for the first time for any part of the Final Examination.

All fees must be paid not less than three days prior to the day on which the examination commences.

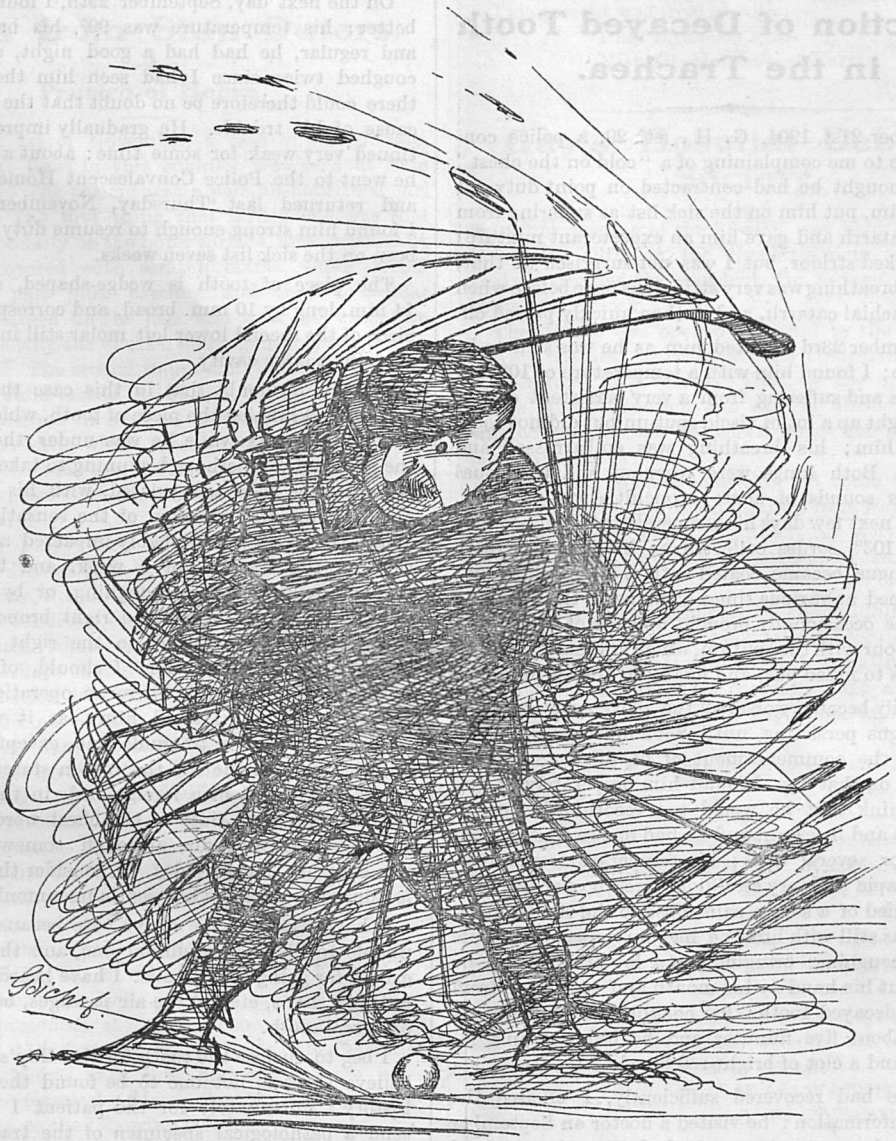
Synopses indicating the range of subjects in the Examination in Chemistry, including Chemical Physics, Practical Pharmacy, Elementary Biology, Physiology, Forensic Medicine, and Public Health may be obtained together with the regulations.

NOTICE TO UNIVERSITY CANDIDATES.

Candidates are reminded that they should send with the Schedule of Certificates when applying for admission to the Final Examination a certificate from the Registrar or other official of the University showing that they have passed examinations in the subjects of the earlier examinations of the Board.

N.B.—Books of questions set at the several examinations of the Board for each year from 1887 to 1904 may be had on application to Messrs. Taylor and Francis, Printers, Red Lion Court, Fleet Street, London, E.C. Price 6d. each, post free 6½d.

FREDERIC G. HALLETT, Secretary.



J. H. BRYANT, Esq., M.D., F.R.C.P., in a Bunker.

As regards this sketch, the PRESIDENT OF THE ROYAL ACADEMY says: "It has more life in it than any drawing I know; in fact, the only thing which does not seem to move is the ball."

Mr. TRAVIS, the Amateur Golf Champion, says: "I have never met Bryant, M.D., but should much like. I guess he has style."

THE ARCHBISHOP OF CANTERBURY says: "Such language should not be allowed."

THE CZAR says: "Could I engage Bryant to work in one of my Baltic Fleet bunkers (coal bunkers), he would probably melt the ice in Vladivostock during the coming winter."

THE EMPEROR OF JAPAN says: "The successive positions of Dr. Bryant's club gave us the idea of our national flag. Banzai!"

Messrs. BROCK say: "Our 5th of November three guinea pyrotechnic displays are simply not in it."

As EDITOR of the GUY'S GAZETTE we would simply draw attention to the eye, which, strictly in accordance with the Classics, Dr. Bryant is keeping on the ball.

Impaction of Decayed Tooth in the Trachea.

On September 21st, 1904, G. H., æt. 29, a police constable, came to me complaining of a "cold on the chest" which he thought he had contracted on point duty. I examined him, put him on the sick list as suffering from bronchial catarrh and gave him an expectorant mixture; he had marked stridor, but I was not surprised at that, because his breathing was very stridulous once before when he had bronchial catarrh, and it then quickly passed off.

On September 23rd I visited him as he was said to be much worse; I found him with a temperature of 103° F., very restless and suffering from a very persistent cough, which brought up a lot of viscid sputum but did not seem to relieve him; his breathing was embarrassed and stridulous. Both lungs were resonant and the usual adventitious sounds of acute bronchitis were present. During the next few days his temperature varied between 101·5° and 103°, sordes collected on his lips and teeth and his tongue became coated with a thick white fur; he complained at various times of pains in the back and sides and he occasionally brought up clots of blood, of a cinnabar odour with the sputum, which gradually changed from mucus to muco-pus, and finally to almost pure pus.

He steadily became worse, all the above symptoms and physical signs persisting, until September 28th, just a week from the commencement of his illness; when I visited him on that day, I found him desperately ill and began to think that he would not recover; his cough was terrible and incessant and he had had in consequence no sleep for several days; his temperature was 103°, breathing rapid and very stridulous, breath offensive, and he complained of a severe pain close to the right nipple. While I was still with him, he had an unusually severe attack of coughing, bringing up a lot of pus, and he suddenly put his hand to his mouth and took therefrom a piece of decayed tooth; his coughing continued very severe for about five minutes and he brought up a lot more pus, and a clot of bright-red blood.

When he had recovered sufficiently, I elicited the following information: he visited a doctor on September 18th last, to have a tooth extracted; he was given gas and when he recovered consciousness, he found that the top of the tooth had been broken off, and he had a sensation of something sticking in his chest (here he pointed to the first piece of his sternum): he told the doctor he thought he had swallowed the tooth, but the doctor said the gas made him feel like that; the sensation remained until the evening of September 27th, but he had not told me about it before, because he thought it had nothing to do with his illness. On the evening in question the sensation shifted to the neighbourhood of the right nipple and this sensation increased to actual pain; when he brought up the tooth, he said it seemed to come right up from the latter place.

On the next day, September 29th, I found him much better; his temperature was 99°, his breathing quiet and regular, he had had a good night, and had only coughed twice since I had seen him the day before; there could therefore be no doubt that the tooth was the cause of his trouble. He gradually improved, but continued very weak for some time: about a fortnight ago he went to the Police Convalescent Home at Brighton, and returned last Thursday, November 10th, when I found him strong enough to resume duty; he had thus been on the sick list seven weeks.

The piece of tooth is wedge-shaped, and measures 14 mm. long by 10 mm. broad, and corresponds with the piece of the second lower left molar still in its socket; it contains a large cavity.

There is no doubt that in this case the unfortunate patient had inhaled the piece of tooth, which had slipped down his larynx while he was under the influence of the gas, and was perhaps beginning to take deep breaths, after having been asphyxiated, with his glottis widely open. From the situation of the sensation referred to above, the tooth was probably impacted at the bifurcation of the trachea for a week, and then, loosened perhaps by an attack of coughing, or by some sudden movement, slipped down the right bronchus, where it caused the pain referred to the right nipple. Had I heard this history before I should, of course, have sent him to a hospital, where an operation would have probably quickly relieved him; as it was I had no symptom nor sign to guide me except the stridor, and that misled me for the reason stated above. The other usual signs of a foreign body in the trachea were absent, since both sides of the chest were resonant and the vesicular murmur, although somewhat deficient, was equal on the two sides. I consider the patient very fortunate not to have had septic pneumonia.

I have recorded the above case because I have been unable to discover a similar one, and this must be my excuse for going into details. I have heard of false teeth, buttons, shells, etc., in the air passages, but never before of a real tooth.

I beg to enclose the tooth for the Guy's Museum, as I believe there is not one to be found there with such a history. Fortunately for the patient I am unable to send a pathological specimen of the trachea with the tooth in situ.

R. P. MARSHALL.

143, Grange Road, S.E.

Papers by Guy's Men.

The Treatment of Obstructed Labour when caused by the Impaction of a Tumour in the Pelvis. Illustrated by four cases. By Thomas H. Morse, F.R.C.S. Eng.—*Lancet*, 12th November.

On Civilization. By W. Arbuthnot Lane, M.S., F.R.C.S.—*Clinical Journal*, 9th November.

Notes from Skin Outers.

Prurigo of Hebra.

On Tuesday, 1st of November, a case of this disease, uncommon at least in this country, was seen at Skin Out-patients. The patient was a pale, ill-nourished girl of thirteen. The first thing that struck one was that her arms, especially on the outer surface, were practically completely covered with scratch marks, small blood-crusts, and pale pink papules, and that a similar condition obtained on the legs, and to a less extent on the face, especially the cheeks, and again to a less degree on the trunk. The second impression borne in upon one was that the child looked ill and that the dull, lack-lustre condition expressed in her eyes and expression, was also evident in her skin, which was dry and rough, and her hair, which reminded one of the coat of a sick animal—that is to say, like both the child and her skin—was dry and lustreless.

Sir Cooper Perry drew attention to the following points: The disease had existed since infancy; it was worse, as a rule, during the summer months. That the rough, coarse condition of the skin was due to scratching and constituted what was known as "lichenisation." That, what perhaps should be looked upon as the primary lesions are better felt than seen, and known as the "pale subepidermal papules of Hebra" (in this particular case they were demonstrated best in the skin of the back). That the inguinal lymphatic glands were enlarged, and that though enlarged they were painless, thus to some extent resembling the enlargement met with in Hodgkin's disease. That the popliteal spaces were spared from the trouble, which should be expected to affect the extensor rather than the flexor surfaces.

Sir Cooper ordered her:—

Ung. Glyc. Plumb. Subacetat.
Mist. Ol. Morrhuæ et Ferri.

On 9th February, 1904, another case of the same disease was presented at Guy's. Here also the patient was a girl, æt. 11 (a fact it is interesting to note, inasmuch as Malcolm Morris says that males are more often affected than females). Here also Sir Cooper Perry drew attention to the following facts:—

1. The appearance at an early age (here it had first been noted at three years).

2. The presence of the pale epidermal papules of Hebra.

3. The enlarged, painless glands in the groin.

4. The intense itching causing the papules to be scratched off and leave scabs.

5. That the disease was singularly intractable.

6. That it was an open question if lichen urticatus leads up to it.

7. The prognosis should be extremely guarded as unless it can be cured when very young the disease usually persists throughout the patient's lifetime, although varying in severity from time to time.

This patient was treated with:—

Ung. Hyd. Ox. Flav.
Mist. Ol. Morrhuæ et Ferri.

G. SICHEL.

Guy's Hospital Debating Society.

The first meeting of the Session was held on Saturday, November 12th, in the Smoking-room. The society again welcomed its president, Dr. Savage, who took the chair at 8 o'clock.

The debate was opened as usual by the discussion of private business, after which the chairman called upon Mr. Myott to propose—"That, in the opinion of this house, the production and sale of alcoholic liquors in this country should be placed under the control of the Government."

The opener took a long time to come to the point, opening his speech with a quotation from Pope. Adducing examples from other countries, he ably showed the advantages of Government control of alcohol and its sale.

Mr. Bell-Walker opposed. Though fully recognising that something should be done, he deprecated any action on the part of the Government, illustrating the failure of previous attempts at coercion. He advocated the waiting policy, trusting to evolution and private enterprise.

Mr. Spriggs seconded the proposer, and Mr. Edey the opposer.

Dr. Savage, in a short speech, then laid the subject before the meeting. The following gentlemen took part in the debate: Mr. Goble, Mr. Wacher, Mr. Watney, Mr. Peall, Mr. Stebbing, Mr. Digby, Mr. Barrionuevo and a visitor.

After summing up in a short pithy speech, Dr. Savage put the motion to the vote, when it was lost by

19 votes to 15.

The society hopes to hold meetings once a month during the winter and will heartily welcome all comers. New men are especially invited to attend.

H. A. WATNEY, } Hon.
G. F. STEBBING, } Secs.

Appointments.

Civil.

Dr. P. H. Pye-Smith has been reappointed representative of the University of London on the General Medical Council.

Dr. Lauriston Shaw has been reappointed Honorary Secretary to the Faculty of Medicine, University of London.

On the nomination of the President of the Royal College of Physicians of London, Dr. Frederick Taylor has been appointed a visitor of the Examinations in Tropical Medicine.

Reviews.

The price of books submitted for review should in every case be stated.

The Surgery of the Diseases of the Appendix Vermiformis and their Complications. By W. H. Battle, F.R.C.S., and E. M. Coner, M.B., F.R.C.S., pp. 208. (Archibald Constable & Co.) 7s. 6d. net.

The authors of this book are to be congratulated on having written a complete and most interesting treatise on an important branch of surgery, in which, however, the medical aspect of the disease is by no means neglected. The pathology of the subject is very well treated, and we particularly like the chapter on the "Acute Abdomen" and its Treatment: here we are told that the most important aspect to be discussed is Operation or no "Operation?" rather than the differential diagnosis as to cause. The first chapter opens with a history of the disease, and it is interesting, in the light of recent events, to note that "Sir Samuel Wilks, in 1875, insisted on the great importance of the rôle which the appendix played in the production of local abscesses and diffuse peritonitis." We also learn that Mr. Symonds was the first in this country to operate on Appendicitis *à froid*—or during the quiet period. All the statistics and most of the cases quoted are drawn from the practice of St. Thomas's Hospital; the figures given agree with those usually accepted. Great emphasis throughout the book is laid on the importance of rectal examination as a routine practice in this disease, for not only can an abscess be occasionally felt to be pointing there; but also, as the appendix nearly always lies internal to the cæcum, a definite tender spot can often be felt high up on the right side of the rectum, some time before anything definite can be felt on the abdomen, so enabling a diagnosis to be arrived at. Descriptions are given of the various operations usually performed, and the authors claim to have originated the method of opening the rectus sheath and drawing the muscle inwards: in connection with which they point out that during life the rectus extends much further out than it does in the cadaver, it reaches three-fifths of the distance from umbilicus to anterior superior spine. It is amusing to note that "a blood count is of some value, especially to those of limited experience of these cases." A chapter on the relation of this disease to Life Insurance ends a most interesting and valuable work, which embodies all that is at present known on Appendicitis, and will take a leading place in the literature of surgery.

Clinical and Pathological Observations on Acute Abdominal Diseases. By Edred M. Corner, B.C. (Cantab.), F.R.C.S., pp. 98. (Messrs. Constable & Co.) 3s. 6d. net.

This book contains the subject-matter of the Erasmus-Wilson lectures for 1904, expanded by the addition of several chapters, which it was found necessary to leave out in delivering the lectures. The author endeavours to bring the pathology of acute surgical diseases of the alimentary tract into harmony with abscess formation in other parts of the body. He first of all shows that all acute perforations and strangulations of the intestines are examples of infective necrosis, and that bacterial invasion, not cutting off the blood-supply, is the principal cause thereof. The mesentery can be stripped from the bowel for one to one and a half inches without causing gangrene of that part of the gut. The cæcum constitutes a natural "rest" for the products of digestion, where fluid is absorbed, and the fæces become solidified and of proper consistency for the large intestine to *grasp* them. As a consequence this viscus forms a breeding ground for many pathogenic bacteria, which are taken up by the lymphoid tonsil of the appendix, and so are the cause of the frequent attacks of appendicitis.

Having proved that bacteria are more important than blood-supply in acute cases, the author goes on to show that pyogenic cocci are a more important factor than B.C.C. The more acute the case the more cocci are found, while, as time goes on, the cocci tend to be crowded out by the B.C.C.; so that, if the fatal end be warded off for a short time, a pure culture of B.C.C. can be obtained from the lesion. The cocci produce necrosis, and are then killed by the B.C.C. for which they have produced the breach. "History is repeated . . . and revolutionary leaders are killed by the very rabble they raise."

Mr. Corner is to be congratulated on his very able and interesting contribution to the pathology of acute abdominal diseases.

Elementary Practical Physiology. By John Thornton, M.A., pp. viii. and 324. (Messrs. Longmans, Green & Co.) 3s. 6d.

This is a very elementary treatise on Physiology with a description of a few experiments at the end of each chapter. Nothing new is expounded, but all the elementary facts are explained in simple language: no knowledge is taken for granted on the part of the reader, and the first lines of chemistry and mechanics are explained where necessary. There are some excellent pictures and diagrams; part of the book is devoted to anatomy, and a glossary is included at the end. A book that should prove useful in schools where physiology is taught.

New Methods of Treatment. By Dr. Laumonier, translated from the French by H. W. Syers, M.A., M.D., pp. xviii. and 321. (Archibald Constable & Co.) 7s. 6d. net.

The author of this book has endeavoured to furnish medical men with definite and complete information concerning many new drugs and methods of treatment, whose worth have recently been established. Laymen, he considers, are often very well acquainted with the latest therapeutic fashion and request a trial of it in their case; but the Frenchman must be more highly

developed than his English equal if his knowledge extends to *Quinoformine* or *Disodic Methylarsinate*—to mention two of the drugs described.

Each chapter opens with an account of the physiological work which has been done in investigating that particular line of treatment—in fact the whole book smacks rather of the laboratory than the bedside; and we must confess that we are greatly impressed with the futility of ultra-modern drug treatment. As a scholarly account of a certain branch of physiology, this book should be read by all who wish to be *au courant* with modern research.

Anti-Typhoid Inoculation. By A. E. Wright, M.D. (Dublin), pp. x. and 76. (Archibald Constable & Co.) 3s. 6d. net.

To Dr. Wright the practical introduction of inoculation as a prophylaxis against enteric fever is entirely due, and in this book we have a reprint of three papers contributed by him to the *Practitioner*. He uses actual cultures of the bacillus, sterilised by moderate heat and a small amount of some antiseptic, which is added. The result of infection is first of all a lowered resistance on the part of the patient to infection—a negative phase of immunisation, the length of which varies with the dose—it is soon, however, followed by a positive phase, during which, if a whole regiment be considered, the total case incidence and case mortality are both much diminished. All the statistics are derived from observations on the British army in South Africa, Egypt or India—and we are given a chapter on the "Fallacies of Statistics." Standardisation of the cultures is carried out by actually counting the bacilli in a given sample—a much more scientific method than the adoption of a variable guinea-pig as an arbitrary standard. A clear account of a most excellent piece of research.

Pass List.

Final Conjoint Examination, October, 1904.

MEDICINE, SURGERY AND MIDWIFERY.—*A. E. F. Kynaston, *J. McF. W. Pollard, *C. M. Stevenson.

MEDICINE AND SURGERY.—*A. R. Beaumont.

SURGERY AND MIDWIFERY.—A. D. Crofts.

MEDICINE ONLY.—H. M. Clarke, *J. Cook, *A. Leeming, *A. S. Littlejohns, A. V. Maybury, *G. H. Rees, *F. Rogerson.

SURGERY ONLY.—*A. M. Benett, *G. Carlisle, *C. H. Denyer, R. Edridge, *F. C. R. M. Knight, *W. T. P. Meade-King, S. M. Wells

MIDWIFERY ONLY.—R. D. Barron, H. P. Costobadie, L. Doudney, *R. Felton, R. Franklin, B. W. Lacey, H. M. Langdale, R. P. Lewis, M. de L. Robinson, H. D. Wyatt.

* Denotes completion of examination.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Historical Guy's.

DEAR SIR,—Someone, cynically, has defined history as "a fable on which all men agree," and someone else, more spitefully and less epigrammatically, has likened the antiquary to the bower-bird that adorns its nest with the iridescent wing cases of dead bugs. To those of us who take a more active interest in our environment than cynics usually do, neither definition nor parable will seem true. Especially false will it appear to those of us who, wandering round Guy's, find so few that can tell of its history, and so little preserved in its museum or its ward that is reminiscent of its long evolution and the gradual development, phase by phase, which it has seen taking place in those branches of science with which we, as medical men or students, are more particularly concerned.

On the Continent, where chairs of historical medicine are recognised and distinguishably filled, every hospital of importance has its historical corner in its museum where visitors can see, and students learn from, this or that special feature which the hospital has been concerned in, either in the modification of surgical instruments or the perfection of clinical apparatus. At the Salpetriere, in Paris, at the military hospital in Antwerp, and at most of the German schools such collections can be seen. Here, where at least one learned society has admitted the utility of historical investigation, we have perhaps nothing similar, with the exception of the incomplete collection of surgical instruments placed in a back room at Lincoln's Inn Fields. Isolated items, of course, there are many; some useful, others, like our own "Certificate for the cure of the king's evil," in the pathological museum, and the skeletons of "Dignity and Impudence," at the Middlesex, mainly sentimental. What is wanted is a better arrangement of and a larger interest in such things. It is now almost two hundred years since Guy's has been in existence, and during that time how much have not Guy's men added to physical science? One and more than one chapter of the history of modern medicine is in effect a part of the history of this Hospital.

Of all this, how much is there in the Hospital itself that perpetuates it? There is material enough for our corner. There is Guy himself and all the worthies to be read of in the Dictionary, of whom we have not even got the portraits. At University College exists an almost complete set of the photographs of professors of that institution, a set which cannot but be of use in later years. Here, in the wards and museum buildings, stand busts or hang slabs, but many of them are titleless, and with a curious similarity of feature that makes one

suspect that they were "faked." Sir Astley's bust is stuck away in what, on a winter's day, is certainly one of the gloomiest spots in the Hospital, and how many of us can locate that excellent bas-relief to the memory of Mr. Durham? At the present time when the new museum buildings are rising to completeness, it may not be amiss to appeal for a special corner or shelf which may be "monumentally Guy's," and where our historical relics may find collective rest. The existence of such a corner would be an inducement to those who have other relics, of interest to Guy's men, to forward them, and who can doubt that there exist many such relics, not the least interesting of which is Cooper's subpœna in the great Guy libel case? An authentic series of photographs of old and present staff members and of those who, though not members of the staff, held the name of the Hospital high outside its walls, should not be difficult to procure. Equally easy should it be to rearrange the busts and monuments where they are better seen and consequently better appreciated.

And here, in conclusion, it may be permissible to ask what has become of the Washbourn Memorial Committee? This committee, as Guy's men will remember, was formed some time after the late Dr. Washbourn's death. It numbered amongst its members many of the late Assistant Physician's provincial as well as metropolitan contemporaries, and was empowered, if we recollect rightly, to consider suggestions for an appropriate method of recording his connection with this Hospital. Since then, however, nothing further has been heard of the committee. Is it possible that it no longer exists, or is it merely the old excuse that pressure of professional business gives us no time to spare for what some people call "sentimental associations?"—I am, Sir, yours, etc.,

P. R.

The Centurions Dinner Club.

DEAR SIR,—May we be allowed to add a few words in order to more fully explain those circulated *re* the Centurions Club.

It was, and is, our intention that the first dinner should constitute a general meeting, at which the present committee will resign, and a new one be elected.

Any additional names for membership may then, or in the course of the first year, be submitted to this new committee.

It may be pointed out that the space for the sum forwarded was purposely left blank, so that any gentleman could, if he wished, bring friends.

The list of names published was never intended to be comprehensive.

Thanking you in anticipation for kindly inserting this.

Believe us to remain,

Yours truly,

THE TEMPORARY COMMITTEE.

Cavillings.

The Editor is a splenetic little thing, and he always reminds me of Quilp, only he never will be persuaded to walk into the river during a fog. He has asked me to write something daring and cynical—as if I could! Cynicism belongeth not to me who have had all the blessings of prosperity, both in my domestic life and my hospital career. I, who have vanquished all my exams. without difficulty, have a cellar full of gold medals, and have obtained all the appointments I desire, and now behold the world at my feet, can only look with kindly eyes upon the rest of my kin. Wealthy practitioners, with bearing-reins and india-rubber tyres and gutta percha morals, beckon to me and whisper "Come, be a partner." Provincial hospitals with snug billets and big subscription lists cry aloud "Be House-Surgeon." Thousands of patients of the well-fed gentry order who know me not, yet with piteous, though inarticulate voice, beseech me "Feel our pulse." The fact is, the world is too happy; I am overwhelmed with pleasant prospects, and vistas of thornless tracks.

Faith it is a fine world and a noble profession! And you, O my son, who have just joined the Æsculapian world have allied yourself to no sordid clique, no cut-throat gang, no gathering of those who hold honour cheaper than success, or well pleased conscience than advertisement. Truly we stand alone in a world of knaves. Uprightness, sterling honesty, courage to stand alone are our trade marks. It moves me to admiration when I see local practitioners, though needy and weary of the struggle, refuse to receive a fee at another's expense, or to listen to the breath of scandal, which, if spread, would tarnish another's fair fame. Rather would he suffer his tongue to be torn from its root than instil into a would-be or actual patient's mind doubts of another's capability or fair dealing.

But most of all, I do admire the humble club-doctor; he has the burden of many clubs, and they may or may not prove the means of spreading his reputation; of that he little recks. His patience, his skill, his time are laid out to the utmost for the humble "Clubber." With careful examination, well-thought-out diagnosis, and the best drugs at his command, does he treat them; for they are to him a sacred charge, and he thinks, not of the smallness of the fee or the degradation of the patient; he has assumed their care as his guerdon, and he will see that he fails not. Oh, thrice faithful heart, may many grateful faces line your path to heaven and your declining years be lightened by the knowledge of a duty well performed.

But assuredly I must not stay my hand at this point in the narration of his qualities. He fears not any man. Great is the truth, and it shall prevail. He tells the truth who holds it dear. It may cost him a patient here and there, it may mean an enemy made, it may mean a rival's opportunity; but of that he does not dream.

Does Mrs. Adipo de Constipati Glutti drive up in furs and rugs to consult him about her weight, he tells her that what she needs is a month of charwoman's exercise and bread and water. What she would wish him to say would be that her nerves are high tension, and that her hepatic functions are sluggish because of the over-active brain. Does poor Mr. Feeble-mind, with well filled money bags, imagine he is a chronic invalid and would like the doctor to come every day, he must go to the quack to be satisfied, for we tell him we cannot pander to a mind diseased or fill our pockets to satisfy a whim.

Oh yet I hold with him who prates
That honesty and virtue blent,
Alone will yield the heart content,
The key to the celestial gates.

What tho' the world hold out her lures
To tempt me from the narrow track
To lose the prize in looking back.
I hold to Truth and she endures!

I may be clothed in motley rags,
Dark hunger may assail my maw,
Still know I where abides the law
Of right: take hence your money bags!

I'd rather vigil through the night
To snatch from Death's approaching arms,
With all my Æsculapian charms
To wage a fierce relentless fight,

To save the navvy from the grave
Whose strong arms mean the bread of life
And home, to mother, child or wife,
Though he be Christian man or knave,

Than kneel beside the royal bed
With accents gentle, reverent mien,
Deplete of grume the regal spleen
And rise a courtier baronet.

Then if we do not know what is the matter with Mrs. A. we say so, and offer her a prescription which we explain contains rhubarb, and which may do her good and can do no harm. She may take offence and say, "I thought thou wouldst strike thy hand on the place and recover me," but she must abide. She may go the breadth and length of the land but she will not find one of our profession who will say he knows when he does not.

My son, take heed you fail not of your high heritage. To you is the example and to you the tradition. Dare quam accipere.

SENEX SED NON SENILIS.

Sport.

FOOTBALL FIXTURES.

Saturday, November 19th.

G.H.R.F.C., I., v. Old Merchant Taylors, home.
II., v. Civil Service II., away.
III., v. Ealing II., away.
G.H.A.F.C., I., v. Surbiton Hill, home.
II., v. Surbiton Hill II., away.

Saturday, November 26th.

G.H.R.F.C., I., v. London Irish, home.
II., v. Old Dunstonians, away.
III., v. King's College Eng., II., away.
G.H.A.F.C., I., v. Old Cranleighans, home.

Saturday, December 3rd.

G.H.R.F.C., I., v. Richmond, away.
II., v. Old Millhillians, away.
III., v. N.C.S. Old Boys, away.
G.H.A.F.C. I., v. Beckenham, home.
II., v. Croydon Park II., away.

HOCKEY FIXTURES.

Saturday, November 19th.

G.H.H.C., II., v. Hampstead III., at Kidbrooke.

Saturday, November 26th.

G.H.H.C., I., v. Malden, at Kidbrooke.

Saturday, December 3rd.

G.H.H.C., I., v. Bromley, at Bromley.

Rugby Football.

GUY'S v. STREATHAM.

This match was played at Honor Oak Park on Saturday, November 12th. Streatham kicked off and Guy's at once attacked, the halves got the ball away from the scrum to McEvedy, who made a good run. Saunders dashed through, and kicking the ball to the full back, managed to get it again and pass to Mullins, who passed to Pinching, the latter scoring under the posts. McEvedy converted. After the kick-out, McEvedy got the ball, and running from the half-way line, scored under the posts and kicked a goal. Soon after McEvedy got hurt and retired for a short time. The ball came out from the scrum and going through all the three-quarter hands Stringer handed to Gibson who scored wide out. No goal resulted.

In the second half, Webster and Jones at half completely outplayed the Streatham halves, Jones making some good runs. Early in this spell the three-quarter passed and McEvedy gave the ball to Stringer, who scored, no goal resulting. Streatham kicked out, and from a scrum at the twenty-five line Webster picked the ball up well and passed to McEvedy, who went through in brilliant style and scored, kicking the goal himself. Just before no side was called, Alcock made a characteristic run and scored, McEvedy again converting. Guy's were left winners by 4 goals and 2 tries (26 points) to nil.

GUY'S III. v. LENNOX III.

Played at Cricklewood on Saturday, November 12th. Guy's won easily by 4 goals 9 tries (47 points) to nil. Tries were obtained by Monaghan and Harvey (3 each); Wacher, Palmer and Lloyd (2 each), and Whelon (1); Palmer converted three and Kidd one. Team:—

GUY'S.—G. E. Penny (back), G. Wacher, B. H. Palmer, L. Lloyd and T. R. Harvey (three-quarter backs); P. J. Monaghan and C. E. Whelon (half-backs); L. Doudney, W. S. Kidd, G. B. Cockrem, G. Hind, M. M. Adams, T. Stout, R. Stout and C. H. Peall (forwards).

GUY'S III. v. EPSOM COLLEGE.

Played at Epsom on Tuesday, November 15th. Guy's winning by 3 goals, 1 penalty goal, 2 tries (24 points) to nil.

Guy's kicked off up the hill with the sun in their eyes. Owing to a bad kick by Harvey, Epsom pressed, and Guy's were forced to kick dead. From this point, Guy's pressed, and Harvey got over; Tolhurst failed to convert. Soon after, Tolhurst kicked a goal from a penalty. A few minutes before half-time, Baker obtained a try and Tolhurst added the major points. During the second half, Guy's pressed nearly all the time. First, L. Reynolds crossed their line from an opening by Saunders, and Harvey converted; then Wight got over in the corner, but Tolhurst failed at the kick. At the last minute Baker again scored after a good piece of passing; Harvey converted. Team:—

GUY'S.—R. S. Bennet (back); J. P. Jones, W. S. Digby, H. F. Wight, T. R. Harvey (three-quarter backs); L. T. Baker and P. J. Monaghan (half-backs); S. Mc K. Saunders, A. H. Tolhurst, L. L. C. Reynolds, D. Reynolds, J. Hodson, M. M. Adams, E. L. Elliott, J. L. Atkinson (forwards).

Association Football.

GUY'S v. OLD WESTMINSTER'S.

This match took place at Honor Oak on Saturday, November 12th, and resulted in a win for the Hospital by 1 to nil.

In the opening half the play was fairly even, and at half-time there was no score. Afterwards we had much the best of the game, and Wearing scored the only goal of the match. We certainly ought to have added considerably to our score but the shooting of our forwards was very weak. Team:—

GUY'S.—E. Wood (goal); A. G. Jones, A. R. Wilson (backs); P. V. G. Pedrick, A. F. W. Denning and H. P. Aubrey (halves); E. Wragg, P. C. Litchfield, D. J. Wearing, E. Barnett, and T. L. Jones (forwards).

REMARKS:—Wood had little to do in goal, but shaped well when he was called upon. Both backs played well, and Wilson's kicking was very safe. There was no combination among the halves and forwards, and the shooting was very weak.

GUY'S v. EWELL.

On Saturday, November 5th, we played Ewell at Honor Oak, and managed to win by 2 to nil.

This result is very satisfactory considering that after the first ten minutes we played with ten men owing to Zorab hurting his leg and having to leave the field.

In the first half we had rather the best of the game, and Barnett opened our scoring after a good run by the left wing.

In the second half play was mostly in midfield, but shortly before the end Piper scored again with a long shot. Team:—

GUY'S.—E. Wood (goal); E. N. Plummer and A. R. Wilson (backs); P. V. G. Pedrick, A. F. W. Denning and A. Zorab (halves); E. Wragg, P. C. Litchfield, D. J. Wearing, E. Barnett and S. A. Piper (forwards).

Guy's Hospital Hockey Club.

I wish to call the attention of members of this club to the following note, which I have been asked to write by the captain and committee:—

It mainly resolves itself into a complaint of the slackness and lack of keenness shown by too many members, and therefore will not apply to those men who *are* keen, and have shown themselves to be such. The chief cause of complaint is naturally that of turning-out for matches and trial games. There seems to be a prevalent idea, mainly amongst the regular members of the team, that it is unnecessary to turn out for trial games, since their worth is known. I would remind them that the whole object of these trials, is to find men who can fill the vacancies in the teams, and that their worth cannot be decided unless they can be compared with the strongest players; also that in the forward line particularly, men should be accustomed to play together in the same places, and that experiments should not have to be made in the matches. There is, moreover, a request which has often been made before, and which cannot be too strongly urged, and it is this—

"If men are enabled to play in any match, will they kindly either inform the captain or secretary as soon as possible, or cross their names off the team list, which appears on the board in the smoking-room, not later than three days before each match."

Three weeks ago, the team went away with only nine men, simply because two men failed to cross their names off the list or inform any official of the club of their inability to play. It is probable that this was due to ignorance, and it is charitable to think so, and therefore I hope that this reminder will serve to prevent any recurrence of such a possibility. I conclude by reminding men that in its present state the club needs keen support from all its members, and this can best be shown by their willingness to turn out on all occasions even at the cost of some slight personal sacrifice, such as delaying one's start for a week-end until *after* the Saturday's match, a small sacrifice which too many men have of late declined to make.

F. MORRES, Hon. Sec., G.H.H.C.

GUY'S v. EALING.

Guy's met Ealing on the Richmond ground on Saturday, November 12th, and an extremely fast if not very scientific game resulted, Ealing winning by 7 goals to 4. Ealing at once pressed but Guy's got away and a good pass from the left gave Ticehurst an opportunity to which he proved equal, scoring with a good shot. Ealing replied after fifteen minutes play by scoring 3 goals in less than five minutes, two more following before half time. After crossing over Guy's got together much better and had rather the best of the game, scoring 3 goals (Wells and Davies 1), whilst Ealing secured two more; latter thereby winning by 7 goals to 4.

Of the Guy's team, Wells in the centre was excellen in the circle; Ticehurst at outside right showed great improvement, and "centred" well, but must try to do so with greater accuracy. Davies was not so good as usual, Clarke must learn to control the ball directly he gets it. The passing of the whole line was very erratic. The wing halves must stick to the wing men exclusively, and must not be "drawn" by the insides, and conversely the backs should not tackle the outside men, so long as they stay on the wing, except in emergencies. Both backs were inclined to under-estimate the great pace of their opponents and got too far up; they should hit harder. Knight was very safe. Moyle was very good in goal, but must repress his tendency to join his forwards.

Hockey Note.

By WARD-CLERK.

GUY'S II. v. PUDDLETON.

This exciting contest took place on the Whackford Hill grounds on Saturday, November 3rd, resulting in a draw for the Hospital by no goals to nil. The ground was in a most tuberculous condition. From the initial bully the Guy's right anterior horn got well away, and making a swift incision into the pedicle of the Puddleton defence, transferred the "cyst" to Porringer, who, playing a dashing game throughout, took the pass on his handle, and giving the custodian no chance to use his retractor, promptly "warded" the "leather." The Registree, however, declined to award the point, and much bruit resulted. A great effusion of septic language followed, and while this was being evacuated the referee "came round" and decided the point in our favour. This resulted in his being immediately "put under" again, however, and much hæmorrhage ensued. On examination, patient was extremely reticent as to his previous diseases, and also as to his family history, but indulged in a lurid description of the ancestors of his interrogator. He indignantly denied that his father was, or ever had been, a sweep, and described himself as a schoolmaster. On examination of his pupils, one was distinctly larger than the rest, which naturally led to a suspicion of Melonostic Achrondroplyæmia. There was no discharge from the nares, but ceaseless effusion of gas from the mouth. Both optics were surrounded by "vicious circles," and there was a regular swelling over the opisthio-glabella suture (salmon-gut). The skin over the latter had undergone much change for the worse. Vigorous palpation of the part elicited no local fluctuation, but seemed to increase the knee-jerks to a marked extent. All "Smith's signs of pain" were present, but there was no "sign of itis." His choler was much increased, and patient was found to have a number of strangulated anathemata in an advanced stage of decomposition on the tip of his tongue. The H.-S. diagnosed a "stroke."

The match ended as stated.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Calendar.

November, 1904.

Sat. 19.—Messrs. Golding-Bird and Dunn's take-in; Drs. A. W. Berry and H. F. Vandermin; Cl., J. M. Barrionuevo.

Physical Society's meeting at 8 p.m. "The Treatment of Cardiac Disorder." H. Mann, M.B.

Tues. 22.—Residents' Dance.

Thur. 24.—Messrs. Jacobson and Sir Alfred Fripp's take-in; Drs. J. S. Bookless and A. S. B. Bankart. Cl., H. H. Carter.

G.H.C.U., Address on "Reality," by A. A. Head, Esq.

Fri. 25.—January Dental Appointment List opened.

December.

Thur. 1.—January Medical Appointment List opened.

Fri. 2.—January Dental Appointment List closed.

Sat. 3.—Physical Society's meeting at 8 p.m. "Thrombosis and Embolism as complications of Surgical Operations." R. S. Anderson.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

Appointments.

Naval and Military.

Staff-Surgeon ROBLEY H. J. BROWNE, R.N., is promoted to be Fleet Surgeon in His Majesty's Fleet.

Staff-Surgeon WALTER J. BEARBLOCK, R.N., has been appointed to the *Hawke* on commissioning.

Surgeon SYDNEY CRONEEN, R.N., has been appointed to the *Cambridge*, and Surgeon CYRIL SHEPHERD, R.N. to the *Colossus*.

Surgeon-Major W. CULVER JAMES, of the Honourable Artillery Company, is granted the honorary rank of Surgeon-Lieutenant-Colonel.

Change of Address.

Dr. J. H. Bryant, from 4, St. Thomas Street, S.E., to 8, Mansfield Street, W.

Dr. W. H. Brailey, from 11, Old Burlington Street to 21, Lansdowne Place, Hove, Brighton.

Mr. W. C. Ball, B.A., from 96, Gower Street, W.C., to 30A, Prince of Wales Road, Battersea, S.W.

Mr. R. H. Jocelyn Swan, M.S., F.R.C.S., from St. Peter's Hospital, Henrietta Street, W.C., to 76, Wimpole Street, W.

Dr. J. G. Taylor, from 3, Upper Northgate Street, to 35, Nicholas Street, Chester.

Dr. J. M. Thorne, from Farncombe, Godalming, to Brockham Green, Betchworth, Surrey.

His Majesty has been graciously pleased to confer the honour of knighthood on Mr. Shirley F. Murphy, Medical Officer of Health to the Administrative County of London.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Births.

CLEVELAND.—On the 9th November, at Norwich, the wife of A. J. Cleveland, M.D. Lond., M.R.C.P., of a daughter.

MALCOLM.—On the 11th November, at 13, Portman Street, W., the wife of John D. Malcolm, F.R.C.S. Edin., of a son.

STAINER.—On November 12th, at 19, Clarendon Road, Southsea, the wife of Courtney B. Stainer, L.D.S. Eng., of a daughter.

ED.—R. E.

GUY'S HOSPITAL GAZETTE.

VOL. XVIII., No. 432.] DECEMBER 3, 1904. [SIXPENCE.

CONTENTS.

	PAGE.
Passim	493–495
Two Cases of Acute Miliary Tuberculosis. Clinical lecture by Dr. W. Hale White	496–501
Notices	501
Change of Address	501
A Case of Depressed Fracture of the Skull with Laceration of the Cerebral Cortex	501–502
Pass List	502
The Piping Times of Peace	503
Correspondence	504
Appointments	504
The Treatment of Cardiac Disease... ...	505–510
Sport	511–512
Review	512

Passim.

IT is difficult to believe that Christmas is really only a short three weeks ahead; it seems only the other day that we were discussing the prospects and preparations for the festive season of 1903. However, there is no room for doubt, and we surrender ourselves once more to anticipations of the busy time that is coming. Honestly we feel bound to confess to a touch of the cynical mood. In the midst of the annual bustle and stir that commences with the going out of November, and lasts until the advent of the New Year, we cannot help wondering how many there are amongst us, who do really take as warm-hearted a delight in Christmas for its own sake as did our grandfathers and grandmothers in days gone by. To many of us this stir and bustle savours so much of the mechanical, there is so little that is really purposeful about the preparations, so little that is original, the community resembling a colossal dervish, who, having outgrown conviction, nevertheless goes through all the approved antics and contortions of the earnest devotee.

AT this season of the year the mass of people are so entirely obsessed by sentimental considerations, that it is possible for small boys to squall carols through keyholes, without being told to move on by the usually prosaic policeman. So enervated are we during the month of December, that we only dare to imprecate in the privacy of our closets when we are awakened in the dead of night by inharmonious howlers of obscure and doubtful points of eschatological import. After all, have waits ever been anything but mercenary, and have we not always suspected that our grandfathers, generally speaking, made up in sentiment for what they lacked in intellect? One isolated case, we know of, in which common sense revolted against the tyranny of sentiment, and a posse of choir boys fled at midnight down a suburban street hastily pursued by a realistic old gentleman armed with a red-hot poker. But generally speaking, the old folk were just the sort of people to foster customs such as we are perpetuating to-day. How does the bell-ringer greet one on a cold frosty Christmas morning? Does he wish you the compliments of the season? Do his eyes fill with tears as he speaks of all that Christmas means to him? No! he dilates on his cold feet, and curses his luck that he has to get up so confoundedly early. Why cannot we look the facts in the face? "What's Christmas time to you," says Scrooge, "but a time for paying bills without money; a time for finding yourself a year older but not an hour richer; a time for balancing your books and having every item in 'em through a round dozen of months presented dead against you?"

BY this time is the idealistic and sentimental orthodox person thoroughly outraged. Let him spare his fulminations; we have done our worst; and not only shall brutal cynicism henceforth be gagged and bound, but we will play the idealist with the best and conjure up false sentiment to run riot for Auld Lang Syne. A Hospital Christmas, of course, does not come under the preceding condemnation, for here we have to amuse others and not amuse ourselves, and that makes all the difference.

NIGGER practices are proceeding with great promise, and there are all sorts of stories of entirely new wheezes and of singers strange and new. We have not yet heard the rhythmic beat of the drum coming from the Charities' room, but we are daily expecting it and so are the Boro' children, who always get a lot of fun out of the practices. Incidentally, we learn that the side-drum is to be in excellent hands. As regards the Christmas week, we hope to publish a full programme in our next number, giving the time of the various concerts which will probably be, as ever, as great an attraction to visitors as to patients, if not a greater.

WE should like to call everybody's attention to the various Christmas funds, subscriptions to which are being solicited by various and sundry. The most confirmed cynic amongst us could not harden his heart to these, for the proceeds of these funds do undoubtedly go to make things brighter for a while, both for the patients in the wards and for the children who crowd Out-patients on Christmas afternoon. This is the one thing that it is the undoubted duty of all to support, if they do nothing else, and we have no doubt that as in previous years the response will be general.

THE Residents' Theatricals in the Court Room are fixed to take place on the Tuesday and Wednesday evenings in Christmas week. The *pièce de resistance* of a triple bill will be some well-known farce with, it is hoped, considerable "writings in" on the part of a gifted playwright, who has yet to be discovered, but who, we have no doubt, will be forthcoming in this hospital of surprises. The female parts are exercising the earnest attention of the stage-manager, who nightly dines in close proximity to the Residents' table that he may advantageously study the varying timbre of the voices of likely Residents. He assures us it is an engrossing pursuit. The first item of the bil will be the duologue "The Ninth Waltz," and the third item will, in all probability, as on the previous occasion, consist of an original one-act play by a well-known Guy's man. It is becoming so very much the fashion for Guy's men to write plays that the bare announcement that another has entered the dramatic lists will not be received with breathless excitement. Rumour, none the less, is busy over the projected play, but we hope that it is not really true that the office of censorship will be offered to Mr. W. T. Stead, nor can we believe that the title of the play will be "Prunes and Prisms."

THE new Squash Court is hastily approaching completion, and should, in fact, be ready in about a fortnight, according to the estimate of one, who from his air of authority purports to be a foreman. It should be fairly safe to say that the Court will be ready for players by January 1st. *Sursum corda!*

We have recently received letters from a few old Guy's dental men complaining that the GAZETTE is not of sufficient interest to dental practitioners or to dental students. We are exceedingly glad that this old grievance has once more taken an acute form, since it creates an opportunity for a statement on our part of the views we hold on this subject, but have hitherto refrained from expressing, as the remedy does not lie in our hands. It is obviously desirable that the varied interests of the Hospital should, as far as possible, be represented in the GAZETTE. Accordingly, fifteen months ago or thereabouts, one or two prominent members of the Dental staff, and a few of the then representative students, were approached on the subject of the opening of a definite column of dental news; the response was lukewarm on the whole, and, we were told that dentistry being in the main practical, did not lend itself to literature to a sufficient extent for the Dental Department to be able to guarantee regular contributions, or in fact, anything more than an occasional note. In the interests of dental readers we did not accept this decision as final, and a similar attempt was made a few months later. An occasional inadequate account of a Dental Society meeting, one interesting article from a free lance at the Paris School of Dentistry, and a paper on Comparative Odontology (the corrected proofs of which were sent in exceedingly late) have been the sole results at present of these two attempts. We should like to point out to the Dental men generally who are dissatisfied with the GAZETTE

on the score of its lack of dental interest, that it rests with themselves whether things shall remain as they are. If it is true that dental literature is uninteresting, even to those who practice dentistry, then no more need be said, but if this is not the case, and if it is merely want of initiative on the part of those dental men who are best qualified to correct this state of affairs, it were better if complaints were in future addressed to the Dental Department.

On the subject of the various payments entailed in the course of a thorough medical education what volumes might not be written? Does an examiner wish to prove to his own satisfaction, at least, that in spite of detractors he possesses a very rich, though subtle, fund of humour? We pay for his pleasure. Is there district work to be done? We pay for the privilege of relieving the Hospital of work with which it could not otherwise cope. Is there a corpse to be dismembered? Yes, at a price! Or we have attained to the giddy eminence of a qualification by hard work and hard cash. May we make use of our new honours? We may do so on payment of a registration fee. Alas, the long list of payments we must make! To all these payments the General Medical Council are desirous of adding one more. This enterprising body is discussing the "establishment of a register of medical students and the imposition of a fee not exceeding £1." The barefaced reason given for this proposed "imposition" is that the General Medical Council may "raise further funds of which it is in urgent need." The audacious honesty of these would-be brigands! We are glad to read that amongst their own number is a certain Dr. Norman Moore, who has protested against "this plan of taxing students and giving them nothing in return," at the same time pointing out that "to obtain funds it was only necessary to convince Parliament and the public that the Council was doing useful work; *at present there seemed to be some doubt whether the Council spent its time wisely.*" (The italics are our own.) We are still more pleased to hear that the Privy Council to whom the scheme has been submitted have declared that there is no need for the innovation.

On Saturday, December 10th, the Debating Society will meet once more in the College Smoking Room. The subject for debate is not a new one but will not lose in interest on that score. "Half-penny Journalism" is once again to be attacked and defended, and we have no doubt that many illuminating things will be said by the way. Mr. Mann and Mr. Thompson are the prime movers in the debate, and they will be seconded by Mr. J. E. Collins and Mr. Penny. All freshmen should make a point of attending this debate, for if we mistake not the signs, the Debating Society will be at its best on that occasion. That Dr. Pembrey will occupy the chair cannot fail to appeal to junior men.

We have been asked to request the men who intend to dine with the prospective Centurion Club to send in their subscription not later than Saturday, December 10th.

The Physical Society's discussion of Cancer was so successful that a similar meeting has been arranged to take place on December 17th. The subject for discussion is to be "Gout." Messrs. Macalister, Myott, Bell Walker and Bellingham-Smith will open the debate.

An Assault-at-Arms will be held in the Pavy Gymnasium on Wednesday, December 14th, consisting of gymnastics, boxing, fencing, and wrestling. Dr. Pavy has promised to take the chair on that occasion. Last year's meeting was crowded and enthusiastic, and we hope that the event of December 14th will be equally successful.

The account of the General Meeting of the Rugby Football Club reaches us too late for sufficient justice to be done to so important a matter, in the present Gazette at any rate. With a few notable exceptions, however, the great majority of Guy's men are in favour of an extension of the present five years' limit. An account of yesterday evening's Inter-Hospital Meeting, called to discuss the question, will be reported in our next.

The next number of the Gazette will be published on December 24th and not on December 17th. This postponement is necessary in order that the Christmas Picture may be issued, as it should be, with the Christmas Number.

Two Cases of Acute Miliary Tuberculosis.

CLINICAL LECTURE BY DR. W. HALE WHITE.
October 29th, 1904.

GENTLEMEN,—Here you see before you the viscera of two children who have died in Clinical ward quite recently, and I think that we shall not be unwisely employed this afternoon if we try to find out something about the illness from which they died. Many of you will be able to see, even at that distance, that there are scattered about, in the lungs, for instance, a number of what we call miliary tubercles. In the first case, they are scattered on the liver and in the kidneys and the lungs; the pulmonary tubercles you will be able to see even from the top of the theatre. In the other case also you will see some on the spleen, some on the kidney, some in the lung, and some on the surface of the liver. These tubercles are shewn most typically, I think, on the peritoneal surface of this piece of liver. They are numerous, small grey nodules; that is how they are described in the books, and they are generally about the size of those you see here. They are called "miliary," because of their size and number, and the disease from which these two children suffered is called acute miliary tuberculosis because it is an acute disease; it kills the sufferers from it in the course of a few weeks. Dr. Sturges, among 1,420 post-mortems at a children's hospital, found that 30 per cent. were instances of tubercle, and that it was under five years of age that tubercle was most active. Again, out of 400 cases of tubercle at the Shadwell Hospital for Children, 25 were pulmonary, 25 general; that is to say, this disease—12 abdominal and 38 cerebral. So you are hardly surprised to learn that this disease which I shew before you is a state of affairs which is common in children, and indeed, it is much commoner in them than in adults.

Naturally, when you have a condition which is commoner in children than in adults, it occurs to you that perhaps it is congenital. If tubercle were a congenital disease, you would expect it to be transmitted from either parent to the child. And there are clearly two possibilities; the tubercle bacilli themselves might be directly transmitted from the parent to the child. In the case of the male parent, as has been shown in animals, that is a possibility; but, fortunately, tubercular disease of the genital organs in man is not common, and the sufferers from it are generally so ill that they are hardly likely to beget children. So for practical medicine we can put out of court the probability that tubercle is transmitted by the bacilli being present in the male organs of generation.

With regard to the female, the question is much more interesting, and I think some of you remember a woman about two years ago in Mary ward, under me, who was pregnant, and who died of phthisis. There have been several cases since. At that time I was particularly interested in this question of the transmission of tubercle from parent to fœtus, and the literature of the subject only contains about six cases in which the female parent has transmitted tubercle directly to her child before birth; there are these half a dozen cases in which tubercle bacilli have been found in the fœtus, in the umbilical blood, and also deposited in the liver, as you would expect them to be if they were transmitted from the mother to the child. They are also found in the placenta very occasionally. In the woman I have mentioned you will remember the placenta was absolutely healthy, and the child showed no evidence whatever of tubercle. The scarcity of cases in point shows that the transmission of tubercle from mother to fœtus is so rare as to be a mere curiosity.

I will not spend more time upon that, because I gave a lecture on the subject only a year or two ago, shortly after that woman died, and it was printed in the GAZETTE. I may, however, mention one other possibility, and that is that the tubercle bacilli themselves are not transmitted from the parent to the child, but that the child inherits a lowered resistance to tubercle bacilli, and hence they will be more likely to germinate in the children of tuberculous parents. That is a very difficult question. I went into it in some detail in the lecture to which I have just alluded, and you will remember that the fallacies are very numerous. For instance, many cases which are supposed to be hereditary are not hereditary at all; the children are directly infected by the tuberculous sputum of their parents. Again, the case in favour of heredity in many instances breaks down on examination, and the result of the discussion which I gave in that lecture was to show you that the best evidence on the subject available was, as you might expect, actuarial; and that a paper published in the Journal of the Institute of Actuaries, by Mr. Manley, an actuary, showed that if one or both parents were tubercular, and the adult person proposing to insure his life were perfectly healthy, you ought to add five

years to his age, in order to counteract the inherited weakness which makes him more liable to be affected by the onslaughts of tubercle bacilli than ordinary people. That does not precisely answer the question, because it only says that his expectancy of life is less; it does not say that he will necessarily die from tubercle. This inherited low resistance to tubercle bears on the cases before us, because the parents of one of these children had tubercle, therefore, perhaps the child inherited a low resisting power to tubercle.

A point of very great importance is that acute miliary tuberculosis is never a direct infection; there is always an old focus in the body from which it springs. Persons dying of acute miliary tuberculosis must have had tuberculosis previously. That is as you would expect, for it would be difficult to see how direct infection could affect, say, the spleen, from without. The primary seat in people who have acute miliary tuberculosis is usually some caseous glands, commonly those at the bifurcation of the bronchus, as you see here. The next most common seat is caseous glands elsewhere, as for example, the abdominal glands or those of the neck. Other things which lead to the development of acute miliary tuberculosis are, chronic tubercular disease in the lung, or in bone, or in a joint, or, in fact, in any part of the body. As proof of what I say, a primary focus can be demonstrated in the post-mortem room in over 90 per cent. of all cases of acute miliary tuberculosis, and as the focus is often very small you may easily, in a child, miss it. As such a focus can be found in over 90 per cent. of the cases, it is fair to assume that it is always present, but that in 7 per cent. or 8 per cent. it is overlooked. This general infection from the primary chronic source can only take place by the blood or lymph vessels; and it must be a simultaneous infection, because you will see that the age of most of these tubercles is about the same all over the body. Probably the way it happens is this: that in, say, the bronchial glands, which are caseous and contain numbers of tubercle bacilli, a small vessel is directly infected by a tubercle growing into it, forming a little eminence on the inside of the vessel. The tubercle bursts, and the whole of the vascular system is infected thereby. Thus the bacilli are swept all about the body, and deposited in certain organs. Occasionally it may be the thoracic duct which is the seat of infection; a little tubercle growing into that bursts, and the bacilli become distributed over the body.

You may well say in answer to what I have said, Why is it that acute miliary tuberculosis is a comparatively rare disease? Literally thousands of people have chronic tubercular glands, or bones, or lungs; Why is not acute miliary tuberculosis more common? The reason is this: Usually, as you can see almost any day in the post-mortem room, the vessel in the neighbourhood of a tuberculous process gets inflamed and becomes thickened. You often see stretching across a tubercular cavity great thick cords. Those are thickened vessels; the vessel is so thick that tubercle can hardly grow through it and form a little tubercle on the inside, and so dissipate the tubercles in the blood-stream. And that is borne out by what I am going to again remind you, that acute miliary tuberculosis is so much commoner in children than in adults. Obviously in children the vessels are thinner, and they are not so big; and in every way it is more likely that tubercle will grow through them. Usually, and indeed I think invariably, it is a caseous and not a fibroid focus which is the primary seat of miliary tuberculosis. The reason is obvious. The fibrous tissue shuts in the bacilli, and they cannot get into the general blood-stream; and if they are shut in for a sufficient number of years they die. You will notice an important difference between the two clinical groups of tubercle, namely, that in acute miliary tuberculosis the tubercle bacilli are actually in the blood, and they can be demonstrated there. In an ordinary case of tubercle—say, tubercular glands in the neck, or in any ordinary case of phthisis—the bacilli are not in the blood; but the patient's temperature is up, the pulse is rapid, and so on, because the toxines from the bacilli get into the blood and keep the patient ill.

It is a point of very considerable practical importance to know which organs are most likely to be the seats of these deposits of miliary tubercles, and I have drawn them up in a list. The commonest seat of all is undoubtedly the lungs; it would be difficult to find a case of acute miliary tuberculosis in which there were not minute tubercles in the lungs. Another common seat is the spleen, and that is affected in both these cases. The next commonest organ is probably the kidney; in both our cases tubercles are present in the kidneys; and it is usually the cortex which is chiefly involved, as here. Deposits are very frequent indeed in the serous membranes of the body. You can see them connected with the peritoneum, over the liver, on the pleura, over the lung. One of our children had them in the pia mater, and this child had them on the pericardial surface of the heart. One of the next most common seats for

tubercles is in the choroid. Unfortunately neither of our cases showed them there. The clinical importance of their presence in the choroid is very great, because that is the only part of the body where you can see them during life. And if they are seen on the choroid there is no doubt about the diagnosis. They are moderately common in the thyroid, and fairly common in the suprarenals.

Now I will tell you the organs in which they are rare. They are decidedly rare in the substance of the liver. That makes this case of particular interest, because at the post-mortem the liver was very mottled and had curious pale areas scattered about which do not show now, and those pale areas it was suggested might be tubercles. Sections of them were cut and Dr. Boycott kindly showed them to us, and there were a number of areas in the liver crowded with tubercle bacilli. Round these colonies of bacilli were several necrotic patches of liver-substance, but tubercles are very rare in the liver. They are rare in bone, but caseous disease of bones is common enough. Miliary tubercles are rare in mucous membranes, but may sometimes be seen there. They are rare in the testicle, they are rare in the prostate, in the bladder, in the pancreas, in the placenta and in the ovary, in the uterus, in the vagina. They are also rare in muscles, rare in the skin and in the substance of the brain. But in all those places they have been discovered. Under muscles I of course include the heart.

There are two or three things which seem to predispose to this shedding of these tubercle bacilli from the caseous source with the consequent production of miliary tuberculosis. Anything which lowers the general resistance of the body will do it, hence if a woman has caseous glands, or old phthisis, she is very liable to get an acute shower of tubercle bacilli in her blood if she becomes pregnant. We have had several opportunities during the last few months in Mary, of seeing how rapidly women go downhill if they are tubercular and become pregnant. Any infectious fever will also lead to acute miliary tuberculosis. The mother of one of these children dated the illness of the child from measles. Whooping cough is another disease which leads frequently to acute miliary tuberculosis. Naturally, of course, operating upon caseous glands occasionally may do it, and I have seen that occur. I am not arguing that caseous glands should never be removed, but when they are soft and suppurating and you are therefore liable to flood the wound with tubercle bacilli, the patient may die of acute miliary tuberculosis as a result of the operation.

You may say that all these lesions in the organs which I show you, are not what you imagine to be miliary tubercles; that is so. I admit some of them, especially in the lung, are caseating. The fact of the matter is, that these cases are such severe instances, that in some of the organs of the body the miliary tubercles are so numerous that they have, with the surrounding inflammation, formed a mass of tubercular deposit which has begun to caseate. That is not uncommon, especially in children. You see it has occurred in the lung and in the spleen. On the other hand, in this other lung, there is very little caseation. In the other organs it has not occurred at all.

There is hardly any disease which gives rise to more difficulty of diagnosis, I suppose, than acute miliary tuberculosis. Unfortunately, we doctors often fail to diagnose it. We so completely fail, I am sorry to say, that it is sometimes not until towards the end of the case that parents are made aware of the necessarily fatal nature of it. On the other hand, not only is it frequently not diagnosed, but it is often said to be present when it is not; therefore it behoves us to look carefully at the symptoms, and when you hear what the symptoms are, I think you will agree that the difficulties may be very great. If, as is often the case, the child is ill beforehand with chronic tubercle, which is the primary source, the additional illness does not show itself very strikingly; consequently you do not have an opportunity of warning the parents of the nearness of the end. On the other hand, as you will see, this disease often produces no physical signs; it simply makes the child weak and feverish, pale and wasted, and upsets the digestion, giving rise to vomiting and diarrhœa. So you may regard the case as one of some gastro-intestinal upset, or one of simple wasting and malnutrition, when really the trouble is tubercular. The most constant symptom which is present in these cases, and was present in both ours, is pyrexia. It is a pyrexia that lasts for a long time, usually during the several weeks the child lives, and it is very irregular, being usually high in the evening and low in the morning, and not by any means equally high in the evening or equally low in the morning of each day. That is very well illustrated in the two charts I show you. Occasionally these cases illustrate what is called the "inverted type" of temperature; that is to say, the morning temperature is higher than that in the evening. In some cases the temperature is even more irregular than

these charts indicate, because some meningitis complicates the case. The temperature is usually lower in adults, especially in elderly people, than in children. Next to the pyrexia, I think, the prostration and weakness is the most striking symptoms of the disease. That was well exemplified in both our patients; both these children got weaker and weaker. It is such a prominent symptom that the doctor is liable to attribute it to some other cause. A third symptom which is very remarkable, and ought always to put you on the alert for this disease, is the rapidity of the pulse. The pulse is rapid out of all proportion to the temperature. I will give you figures from our two cases—140, 148, 140, 156, 160, 156, 160, 178 and 176 and such like rates in our first case. In the other the pulse was 160 with a normal temperature, 180, 148, 164, and so forth. The pulse in these cases is small and feeble. Unless there is some meningitis tending to slow the pulse, you may say that uniformly the pulse is rapid, small and feeble, nearly always as much as 120, and it may rise up to 180. The next symptom also puts the observant doctor on the right scent; the respiration is rapid out of all proportion to the signs of lung disease. Supposing a patient has fever and has not got heart disease nor uræmia, and no obvious disease of the lungs, always suspect acute miliary tuberculosis if the respirations are very rapid. We find here that the respirations were 48, 60, 76 in the first case and in the other case 68, 48, 60, and so on. Another thing which these children hardly illustrate as they lie quietly in bed, but which in adults is better seen, is dyspnœa; and this is very striking, out of proportion altogether to the trouble in the lung. After all, in this lung there is plenty of ærating area, but if the child had been up, the dyspnœa would have been very striking. Patients sometimes come complaining of shortness of breath, and that reminds me to tell you that if a patient is recovering from phthisis, dyspnœa is almost the last symptom to disappear; long after the temperature is normal and the physical signs are quiescent, and the patient's weight has come back, he will still be dyspnœic on slight exertion. Towards the end of these cases there is sometimes Cheyne-Stokes' breathing. Another symptom which will put you on the track is cough. It is often very violent, and with no expectoration as a rule. The reason is not far too seek. You will see afterwards that in this lung, except for the tubercles, there is very little damage to the lung itself; the patient really dies from tubercle before there is time for any great change which would cause expectoration to be set up in the lung.

Again, as you would expect, you must not look for marked physical signs. There did not seem to be much the matter with the lungs of these two children when they came in, in the matter of physical signs—a rhoncus here, râles there, or a little dull patch. In adults especially the physical signs in the disease are very few, and they vary from day to day. Moreover, these signs may occur late in the disease. These tubercles are perhaps no larger than a pin's head, and unless bronchitis or pneumonia supervene you will not obtain physical signs.

It has been said in Germany, but, as far as I know, it has not been confirmed in England, that sometimes these tubercles on the surface of the lung produce a crepitation which can be felt when the patient breathes. I have never noticed that myself.

The next symptom to which, in adults especially, you should attach great importance, I am a little at a loss to explain. I have known the diagnosis of acute miliary tuberculosis successfully made by lividity. These patients are liable to get somewhat livid about the lips and finger-nails; and if you have been watching a case for some days and have been wondering whether the cause of pyrexia can be acute miliary tuberculosis, if the lips and finger-nails get livid it is a strong point in favour of that diagnosis. I suppose it is in some way associated with the dyspnœa which I mentioned to you just now.

Considering how these patients are infected all over, it is not surprising that they are often very listless, drowsy and apathetic. That was so in these two children whose organs are before us, and this drowsiness may occur apart from meningitis. Naturally they lose their appetite, and have a dry furred tongue. I have told you before that the amount of wasting is very remarkable, and that occurs quite apart from diarrhœa and vomiting; it takes place as a result of the tubercular process. But it is interesting to note that in one of these children there was considerable diarrhœa towards the end of the case. The bowels were opened eight times in one day, and seven times on another day. In the other child there was no striking diarrhœa. These patients also sweat profusely, at least adults do. Occasionally there is a trace of albumen in the urine, which is scanty. Sometimes when the tubercles are on the pleura you may get signs of pleurisy, and lastly, there may be choroidal tubercles, which we have mentioned already. You should always look for them.

Now, you will have three varieties of the disease, according to the organs most affected. In the first place, there is a respiratory variety. If a great many tubercles fall upon the lung, so many that they run together, and the child live long enough for the surrounding inflammation to set up some caseous pneumonic patches, then the symptoms will be chiefly pulmonary; there will be patches of dulness, râles, bronchial breathing, and perhaps bronchophony; and the difficulty will often present itself to you of trying to find out whether a case is an example of broncho-pneumonia or of tubercular trouble. It is an important difference, for if tubercular the child will hardly get well, whereas if the disease be broncho-pneumonia it may, although the outlook even then is bad. In these cases the physical signs teach you very little one way or the other. If the trouble is chiefly at the apex it is a little evidence, but not much in favour of tubercle. In *this* case, however, the trouble was chiefly at the base of the lungs, and this was tubercular. Tubercles on the choroid may help you, and you should look for tubercle in the bones or glands, or elsewhere in the body. I think in many cases it is almost impossible to tell whether a child is suffering from pulmonary tuberculosis, or whether it has non-tubercular broncho-pneumonia.

We often see cases in which, owing to tubercles having formed on the meninges, the case presents itself to us as one of tubercular meningitis. We cannot go into the symptoms of that to-day, but one of these cases had meningitis, and this other one has interested us very much, for the child had retraction of the head, and I confess I thought, when I looked at the eyes, that it had optic neuritis. But those of you who have looked at the eyes of children know how difficult it may be to pass an opinion, for as the eyes often move constantly you may see the optic discs for less than a moment. On other grounds we thought it had meningitis, but at the post-mortem no meningitis could be discovered; I could not find a single tubercle on the meninges. That opens up many interesting questions. In the first place, there is the difficulty of seeing the optic discs of children. Then the child's head was retracted, and I would remind you that, though retraction of the head is an important symptom in meningitis, it often occurs in children who have no meningitis at all. They may become rigid when they are very ill from any cause, and if the rigidity affects the muscles at the back of the neck it may lead to the simulation of meningitis. In fact, in small children, there may be many symptoms of meningitis, but nothing post-mortem to account for them. You may meet with trismus, you may see convulsions, and even epileptiform attacks, rigidity may be in other parts of the body, and yet you may find no meningitis. The post-mortem also reminds us that it is very difficult to say whether meningitis was present or not, because there is no doubt that even one or two tubercles on the meninges may give rise to all the symptoms of meningitis. Though I looked as carefully as I could, and Dr. Boycott also, we could not find any; there may have been a few and we overlooked them. Unfortunately, the sections of the optic nerve have not been a success, but it is just possible there might have been optic neuritis, and no meningitis, because it has been described as occurring in children with acute tuberculosis without meningitis, and they would probably fall into the category of those cases of optic neuritis which occur in febrile disorders. Sometimes the symptoms of tubercular meningitis may completely overshadow the miliary tuberculosis.

Lastly, miliary tuberculosis may first attract attention as acute tubercular peritonitis, but if the meninges are not much affected, and the lungs are not much affected, and the peritoneum is not much affected, you have before you a patient who has had pyrexia for some weeks, is obviously very ill, has a rapid pulse, and has no physical signs in the body, then you say to yourself, Is this disease typhoid fever or is it acute miliary tuberculosis? The difficulty some years ago was much greater than it is at the present time, because fortunately we have now the Widal test to fall back upon. And you know the position with regard to that is, that not every case of typhoid, even if tested in the third week, gives the reaction, but the great majority do, and the vast majority of the cases which give the agglutinating reaction are examples of typhoid fever. So that if you are in doubt about a patient having miliary tuberculosis and he gives the Widal test, it will be a very great help. Unfortunately the test is not often of use till the tenth day of the illness, for the sufferer from typhoid fever does not usually show it till then or even later. A definite typhoid spot will always clinch the diagnosis. It is true that one case has been recorded in which there were spots which several observers thought to be characteristic of typhoid fever, although the case turned out to be one of miliary tuberculosis, but that is most exceptional, and it need not weigh with us in trying to approach the point clinically. The facts I have mentioned will help you in your diagnosis.

All I have to say further is, that miliary tuberculosis is a disease which may last four, six, ten or twenty weeks; usually the patient is dead within twelve weeks. Unfortunately we do not know anything to be done for it. When you have diagnosed acute miliary tuberculosis, you can only hope that your diagnosis is wrong. Although some people have said to the contrary, I do not think the disease ever gets well. For my own part, if the patient got well and I made the diagnosis, I should say I had been wrong. You can only keep up your patient's strength as well as possible and hope that your diagnosis may prove to be incorrect.

Clinical Lectures.

The following Clinical Lectures will be given during the next fortnight:—

Wednesdays, December 7th and 14th, 1.30 p.m., Clinical Surgery, by Mr. Golding-Bird.

Saturdays, December 3rd, 10th and 17th, 1 p.m., Clinical Medicine, by Dr. Taylor.

Monday, December 5th, 1.15 p.m., Lecture by Mr. Fagge.

Notices.

CLINICAL MEDICINE.

Dr. Shaw will hold Ward discussions on selected medical cases on Saturdays in December, from 2.30 till 3.45 p.m.

Change of Address.

Mr. J. Bollard, L.D.S., from Guy's Hospital, to 11, King's Terrace, Southsea.

Dr. David Forsyth, from 11, Trinity Square, to 6, St. Thomas's Street, London Bridge, S.E.

Dr. R. Watts White, from Redlands, Hartfield Road, Eastbourne, to The Old House, Swavesey, near Cambridge.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

The Scientific Press announce that they will shortly publish an Elementary Treatise on the Light Treatment, for Nurses, by Dr. James H. Sequeira, Physician in charge of the Skin Department at the London Hospital.

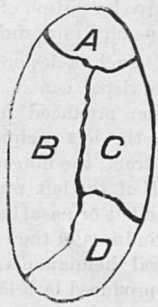
A Case of Depressed Fracture of the Skull with Laceration of the Cerebral Cortex.

The following case is of interest, for two reasons: Firstly, on account of recovery occurring after such a severe injury, and secondly, because the laceration and actual loss of cerebral cortex from an important region were not followed by the symptoms that one would expect from our present knowledge of the localisation of the cortical centres.

Alfred G., a schoolboy, æt. 11, was admitted under Mr. Lucas in July, 1898, with a severe injury to his head. He had fallen from a tree, striking the back of his head against a brick wall. On admission, though conscious, he was suffering severely from shock. The pulse was 100, feeble but regular, and the pupils were dilated, equal and reacted to light. To the left side of the external occipital protuberance was an irregular wound, and above this and to the left, a depressed fracture could be felt. In the wound a gray substance was seen, which was found to be brain tissue, small pieces of which were also present on the stretcher. There was no paralysis, no convulsions had occurred, and the reflexes were normal.

He was at once taken to the theatre and the wound enlarged, exposing a depressed fracture one and a half inches wide, extending from the external occipital protuberance upwards and outwards for two inches towards the left parietal eminence.

Four distinct fragments of bone were found arranged as in the accompanying diagram.



The uppermost fragment A was completely separated and driven into the subjacent cortex. This was removed, as were also the fragments C and D. The former was replaced and the fragment B raised to its normal level.

The dura mater was found to be ruptured, and the cerebral cortex extensively lacerated, portions of it escaping during the operation. The wound was finally washed out with formalin and a gauze drain inserted.

For forty-eight hours after the operation the report notes that, "He wandered in his speech, was delirious

and frequently got out of bed at night." However, these symptoms soon passed away, the temperature remained normal, and on August 15th, a month after admission, he was discharged with the wound quite healed, and apparently in a normal healthy and intelligent condition. No paralysis or abnormal movements of the eye muscles was noticed, and his sight was unaffected.

The patient was next seen in October, 1904, six years after the original injury. He is now a tall, strong, well developed man, certainly looking more than his age. Locally, the original wound and operation scar are completely hidden by the hair, but a broad, very shallow depression can still be made out along the line of the original fracture, and on each side of this, irregular bony masses can be felt. There is, however, no bony deficiency. He states that, with the exception of diphtheria, contracted about six months after his discharge from the hospital, he has not had a single day's illness, and there has been no pain, headache, or any discomfort at the site of his old injury. He describes his sight as perfect and there is certainly no hemianopia. Last year he enlisted and underwent the medical examination without any difficulty, though needless to say, he made no mention of his accident. He has lately been examined again, and has been passed as fit for foreign service in India.

Let us now consider the region of the brain which was injured. If one measures from a point just to the left of the external occipital protuberance towards the left parietal eminence for two inches, we have a line extending across the occipital bone almost to the parieto-occipital suture, and in a boy of eleven, the line would probably extend quite to this suture. Now this line corresponds almost exactly to a line passing diagonally across the occipital lobe of the cerebral hemisphere, from its pole to the junction with the parietal lobe, and hence there was an extensive laceration of the occipital cortex with an actual escape of a fair amount of its substance.

As the result of such a lesion, since the occipital cortex contains the visual centre, one would expect a disturbance of vision produced in the following way. The sight centre in the left occipital lobe is connected with the left optic tract, the fibres of which go to the left or temporal half of the left retina and through the optic chiasma to the left or nasal half of the right retina, thus producing a blindness in the right half of the visual field, or right lateral hemianopia. The effect is thus identical with that produced by a lesion in the left optic tract, and it may be noted that when this condition is present the patient usually turns his head towards the blind side in order that he may distinctly see objects directly in front of him. Now, in the present case, there was no hemianopia noticed after the injury, and there is none at the present time. The latter, however, is not surprising, for even if hemianopia is present after the injury, it may be transient, commisural fibres in all probability enabling the functions of the injured side to be carried out by the uninjured. With regard to the former, it is interesting to notice that Monakow limits the visual area to the cuneus and the lingual lobule, both of which would have escaped injury in the present instance.

Another symptom occasionally found as the result of injury to the occipital cortex is visual aphasia, or word blindness, but this also was not noticed, though it was difficult to examine him for two or three days after his admission.

Examples of recovery after severe injury to the brain are by no means rare, but I think that in this case the severe laceration of the occipital lobe without localising symptoms, and the complete recovery after such a long interval make this case worthy of being recorded. I have to thank Mr. Lucas for kindly allowing me to publish this case.

PHILIP TURNER.

Pass List.

University of London, October, 1904.

M.B., B.S. EXAMINATION.

Honours.

*Arnold Leeming, †Frederick Rogerson.

*Distinguished in Midwifery and Diseases of Women.

†Distinguished in Surgery.

Pass.

William Norman May; John McFarlane William Pollard; Charles Morley Wenyon, B.Sc.

B.S. EXAMINATION.

Pass.

Herbert Myer Goldstein; Daniel Leigh Morgan; Edgar Coningsby Myott.

Royal College of Surgeons of England, November, 1904.

FINAL EXAMINATION FOR THE LICENSE IN DENTAL SURGERY.

Parts I. and II.—*A. Angell, *A. Harris, *P. H. Hickman, *H. M. Peacock, *S. A. Piper.

Part I. only.—W. E. Cook, A. R. Durant, A. Alan Forty, F. H. Fuller, W. A. Helyar, N. James, N. McL. Nibbs, *C. J. Pellow, L. H. Pellow, G. G. Timpson.

Part II. only.—*J. B. Ball, *W. J. Bollard, *V. S. Houchin, *J. W. Mawer, *A. Hammond Smith, *F. S. Vine, *W. J. Wormald.

FIRST PROFESSIONAL EXAMINATION.

Dental Mechanics and Dental Metallurgy.—N. P. Rodgers, H. Simms, O. B. Townshend.

Dental Mechanics only.—*W. T. Dean, R. Beadnell-Gill, *A. S. Thomas.

Dental Metallurgy only.—*A. E. Webb.

* Denotes completion of examination.

A Case of Nodular Leprosy.

The Piping Times of Peace.

"Rats!. . ." Browning's 'Pied Piper.'

[Since the following article is of purely general interest, we recommend all those who are of an exclusively medical turn of mind not to waste time in reading it.

Not long ago it was discovered that considerable damage had been done to the clothing stored in a certain barracks not ten miles from Aldershot.

The officer in charge wrote officially to the War Office suggesting the employment of a cat to keep down the rats. After some delay a Committee was appointed, which in due course evolved a cat of the sealed War Office pattern, and these were distributed to all barracks affected. After a time a difficulty arose as to who should provide rations for the cat. The officer wrote again to the War Office asking that instructions might be issued to cover the case. The Committee met again and drew up a scale of rations for cats—the Financial Secretary being ordered to put in a supplementary estimate to cover the cost of the same.

One day, however, it occurred to some wiseacre at the War Office that these rations cost the country a certain amount of money and that traps would be cheaper in the long run. The Committee were therefore ordered to assemble again, and they approved of a trap which was known officially as "Trap, Mark I. Rats, Wire, Iron, Galvanised." These were to be issued at the rate of 1 for every 100 suits of clothing stored. Our officer indented for 33·3 traps, but was informed by the Ordnance Officer that only decimals above ·5 could be recognised as a whole trap, and in spite of a protest to the effect that some thirty-three suits of clothing would thus be left unprovided for, he found that he could only get thirty-three traps. These, in due course, arrived, accompanied by Army Form B. 1063, which was designed to show the number of suits of clothing stored, the number of rooms in which stored, and the percentage of rats killed to traps employed, worked out to five places of decimals. These forms were ordered to be rendered to the War Office in duplicate once a month.

At the end of the first month the returns were awaited with breathless anxiety and disclosed a horrible state of affairs. There were any number of suits destroyed and no rats killed.

The Committee met again and approved a new trap, which was known as Mark II. The chief difference between this and Mark I. was that it was made of ungalvanised wire instead of galvanised.

At the end of the next month no improvement had taken place in the situation, and the Committee came to the conclusion that there must be something wrong in the method of setting the traps. Officers commanding units were therefore ordered to detail a N. C. O., not below the rank of corporal, to proceed to Aldershot to go through a course of rat-catching, and those who proved themselves to be particularly proficient were given a parchment certificate vouching for the fact that they were competent to catch rats.

At the end of the next month there was no improvement, even in spite of the fact that several surprise inspections had been held to see that these N. C. O.'s were vigilant in their new duties. The Committee therefore decided that the mode of preparing the return was not up to date. This was therefore ordered for the future to be rendered in triplicate instead of in duplicate, and the places of decimals worked out to seven instead of five.

No improvement, however, took place even under these circumstances, and at last it was reluctantly decided that the traps must be returned to store, and the old cat reinstated. The improvement in the number of rats killed was at once most marked, and I believe still continues.

About a month after the traps had been called in, our officer was surprised to get the following communication from the War Office. "With reference to the traps lately in use for the purpose of killing rats, will you please state for the information of the Secretary of State, what bait was used?"

He replied that as no allowance had been authorised for bait, none had been used!!!

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Alcohol and Children.

SIR,—A junior colleague recently handed me the October number of *The Journal of State Medicine*, which contains an article on "Alcohol and Children."

He had marked with blue pencil the following paragraph :—

"An observation, interesting on account of its unusual features, is related as having occurred in Paris. A child's nurse, an old lady of sixty, was engaged in the privacy of her apartment on the delicate operation of stimulating her scalp, and thereby inviting the growth of hair, with old rum. During the procedure, the infant, a babe of ten months, was lying in her lap. The alcoholic fumes evidently affected the baby, for on being taken to the dinner table, half an hour later, he presented a most startling appearance. His bright flashing eyes, flushed cheeks, and excited expression at once attracted the attention of his parents. This increased to alarm when he seized a spoon in either hand, and proceeded to rap a tattoo on the dinner tray in front of him. This performance changed later to wild gesticulations, and, with arms flying and legs kicking, he rapidly passed into a state of wild excitement; after a few minutes he subsided under his table and fell into a deep sleep which lasted for twelve hours. Fortunately, for him, no lasting effect of the drunken carouse appeared later."

This very realistic account especially interests me, because only the other day I was a witness of a similar scene.

A week or so ago I was paying an evening visit to my godchild, who is just a year old. The little fellow, usually a placid infant, was on his father's knee. The father was drinking a glass of constantia after his dinner, and the dinner service had not yet been removed. Little Jack managed to obtain possession of two silver spoons. I soon noticed his eyes flash, his cheeks became flushed, and he shouted at the top of his voice "Goo-goo, Goo-goo" or words to that effect. He jumped himself up and down on his father's lap, his excitement increasing very rapidly and wound up by smashing a big wine glass with the table spoons.

After the spoons had been taken from him, he continued to fidget about and eventually got hold of a box containing the variety of match manufactered at Rosebank, Capetown, warranted not to ignite elsewhere than on the box, and even there only by a fluke.

Jack began to suck the business end of the matches with apparent relish, and his excitement seemed to subside, but that the effect of the deadly fumes had not yet worn off was evident, because when the matches were at last taken from him he flung himself backwards, his spine was arched and stiff, (opisthotonos) his face became still more violently flushed, and, after holding his breath for some time, he gave utterance to a series of fearful cries which could only be called yells.

His mother carried him from the room to the adjoining night nursery where she evidently had much trouble with him. Nothing at first seemed to calm the nervous paroxysm, until she commenced to clap her hands (at least I imagine she clapped her hands to divert his attention, from the sounds which reached us in the dining-room). Then after a period of deep sobbing the little dear fell into a profound sleep which continued until well past daylight.

Next morning he was as bright as a button.

I am writing this description by the light of the knowledge recently acquired from "Alcohol and Children." I must confess that at the time it did not strike me my godchild was suffering from the vapours of alcohol. In fact, during the course of a long life I had frequently witnessed similar scenes, but it had never occurred to me to attribute them to their true cause, the insidious effect of alcohol on the tender infant.

But then, as the author remarks :—

"Perhaps you have not noticed such examples; if that be so, it is only because they have not been sought for. We are apt to pass by things we are not on the watch for or especially interested in, and we are certainly prone to be sceptical of the observations of others, if they happen to be outside our own experience, and, like Nelson, we apply the blind eye to the signal."

There is little doubt I have been blind. I am so no longer.

Of course, Jacky and the other children I have seen were suffering from acute alcoholic poisoning, because although Jacky did not beat a tattoo on a dinner tray, there being no dinner tray handy, he did the next best thing and smashed a wineglass into pieces.

In interpreting signs and symptoms we must not expect complete identity. Nature varies the picture, and I submit that a broken wineglass or, for the matter of that, a kitten bashed on the head, is as conclusive evidence of the awful effects of that pernicious drug "Alcohol" as a tattoed dinner tray.

At any rate, after reading the article my opinions regarding the use and abuse of alcohol have undergone a radical change.—Yours obediently,

P.O. Box 356, GEORGE TURNER.
Pretoria, S. Africa.
November 7th, 1904.

Appointments.

Naval and Military.

Surgeon GEORGE E. DUNCAN, R.N., has been appointed to the *Alacrity*.

Captain H. AUSTEN SMITH, Indian Medical Service, is promoted to be Major, and Lieutenant H. B. FOSTER, Indian Medical Service, to be Captain.

Surgeon-Lieutenant ABRAHAM THOMAS, 1st Cardigan Royal Garrison Artillery (Volunteers), is promoted to be Surgeon-Captain.

The Treatment of Cardiac Disorder.

A paper read before the Physical Society on November 19th, 1904, by Mr. Harold Mann, M.B.

Mr. President and Gentlemen,—I feel that in bringing to your notice the title, under the heading of which this paper has been prepared, some apology were needful. An apology because, from that very moment when you and I as medical clerks first opened the door of the old Mary ward, or climbed the extra flight of stairs to Stephen, the significance of the words "failing heart," and the extremely important part which cardiac disease in all its branches plays in the practice of medicine, have been continually before us. And if you would ask me why I still pursue this matter further, I would reply, that when as a resident one is thrown in contact with those miserables, who are trying conclusions with the Inquisition whose court is by the river, one is struck by the indefinite manner in which most text-books describe the treatment of cardiac disorder. It is true that such works will dilate to you upon the value of rest, and of "digitalis," that talisman for the mitral orifice, but *where* do you learn of the importance of sudden and protracted vomiting, of those night sweats and terrors which arise when "wicked dreams abuse the curtained sleep," of the incessantly wearying cough, the anxiety of dyspnœa, the sickening headache; of the anger of the aortic, the melancholia of the mitral and the agony of angina. Never forget, that the occurrence of any of these troubles may be but the finger writing upon the wall. Let me begin by saying that the main features of this paper have been drawn up as a result of observations made upon a series of some thirty cases which were warded in Esther and Stephen last summer, and also of twenty-five out-patients during the past nine months. With regard to out-patients, no data were taken except from those patients who had been under observation during one month and who had made four separate visits to the hospital.

I propose to consider first to night the subject of—

Functional Disorder.

For one reason, functional cardiac affections are treated of with exceeding brevity in Dr. Taylor's work. They are on that account frequently neglected by the examination man (I know that I neglected them) who finds that when he becomes a casualty officer a very large percentage of his *regular* out-patients fall under the heading of that complaint, and that the importance of careful treatment and observation cannot be over-estimated.

But there is another reason for taking the subject of functional disorder first. Many, I had almost said all, of those disturbances which arise as the result of advanced structural disease in the heart may occur without any morbid alteration in the cardiac mechanism since they are often determined by extraneous circumstances. A distended stomach, a prolonged exertion, a psychical influence may *per se* disturb to an alarming degree a perfectly healthy heart, and the symptoms will be still more alarming, should the organ be rendered more susceptible as a result of previous damage to its valves or muscle-wall. Strictly speaking there is no microscopic post-mortem evidence to be obtained as a result of functional disorder, but the heart may become hypertrophied as a result of prolonged excitement; dilatation may result from disturbance to the mitral apparatus, especially in anæmia, where the myocardium is badly supplied with blood. And again, functional affections are largely responsible for the suffering of those patients who are the victims of valvular disease.

Palpitation is a disorder which, in a greater or less degree, we have all experienced. As you know, it is more common in women than in men. And in the former it may be of a most distressing nature. I can quite imagine that some of you will picture to yourselves cases of hysterical women, unmarried no doubt, and on the autumnal side of five-and-thirty. And I can see you about to prescribe that effervescing draught of our pharmacopœia which, if it has not cured the patient of her manifold ills, has saved many a medical man from those worries which would lead to an untimely end. It is, however, to quite a different class of patient that I would direct your attention. A woman of thirty-two attended at medical out-patients last February complaining of palpitation. She was sensible, well educated, and had come down in the world through misfortune not of her own making. There were no evidences on examination of cardiac disease. She gave a history of previous good health, said that she enjoyed her food and suffered from no ill effects. She was, however, becoming anxious because the attacks had returned on four separate occasions at no particular intervals and from no apparent cause. We had the advantage of seeing an attack while she was in the room, a month after her first visit, apparently due to the alarm arising from the overturning of an electric lamp. During the attack she was in no way hysterical. The whole præcordia was noticed to heave with the tumultuous action of the heart, and it was quite obvious that the discomfort and alarm were most intense. Would you be surprised if the repeated occurrence of such a disorder, should, in one less courageous than this patient, produce within a very short time a nervous wreck? Up to that time she had been treated with strychnine. The use of this was discontinued and four-minim doses of the tincture of aconite were tried three times a day for a week. She was seen every other day. Later this was followed by the administration of Iron, Arsenic and Strychnine:—

℞	Tinct. Ferri Perchlor.	ɱx.
	Liq. Arsenici Hydrochl. ...	ɱiii.
	Liq. Strych Hydrochl.	ɱii.
	Tinct. Digitalis	ɱiv.
	Tinct. Cardam. Co.	ʒj.
	Aquam Chloroformis, ad ...	ʒj,

Cpt. ʒj., t.d.s. p.c.

Subsequently I saw her at intervals during six months, and she had been free from attack. No doubt, in this case, the cause of her trouble was the exceedingly low condition of health into which she had passed, as a result of home troubles. She was fortunately one of those patients who not only listen to advice, but also follow it. Directions as to dieting and general health are no doubt in such cases of extreme importance. In this case, I have made a note, that she was instructed to go to bed every night not later than 9.30 p.m. Three meals were to be taken daily, instead of the usual four. The last meal was at 6.0 p.m., and was not to be the largest meal in the day. She was allowed a cup of beef-tea just before bed-time.

One word before passing on with regard to prognosis. You will find many of them who respond well to treatment. Never on any account tell your patient that she has a "weak heart," by so doing, that confidence which is essential to their cure is shaken, and they soon join that army of melancholics, who, year in and year out, drift from the one to the other of our well known spa establishments without interest to themselves and with profit only to the hotel proprietor. During the acute attack, the treatment should consist of: recumbency, warmth to the legs, smelling-salts or ammonia, with possibly hot applications to the cardiac region. Alcohol is in every way to be avoided. The homely remedy of two drops on sugar very speedily becomes a half-tumbler full.

Another variety of functional disorder which you are certain to meet with is *tachycardia*. The term is sometimes wrongly applied to any case of rapid heart's action, but the group we will now consider is that in which, there is an enormous acceleration of the pulse, in a heart not necessarily the seat of organic disease, at least in so far as the records of necropsies help us. In some cases, however, the attacks may continue for three or four days. This is no place to discuss theories of causation. I will but remind you that the vagi and the accelerators, the cardiac ganglia and muscle, the medullary centres, including the vasomotor mechanism, have all been suggested as the seat of disease. Of the immediate *causes*, over-exertion, dyspepsia, mental shock or emotion, uterine disorders and constipation have been pointed out separately and collectively as the primary seat of trouble. Yours will be the duty of ensuring that these various functions are carried out in such a way as to be compatible with the best possible health to the patient, and that he or she is in no way the victim of nicotine or alcohol.

With regard to drugs, digitalis will be quoted to you in the books as a possible remedy, and morphia is mentioned by Taylor. It certainly sounds dangerous, for there is no one so ready to drift into a habit as a functional cardiac patient.

No. 1.—E. L., female, æt. 42. Attended at out-patients, complaining of weakness. Ten years ago she had rheumatic fever, but until four years ago, there had been no heart trouble, when she first became liable to pain in the chest. On examination, there was a pulse of 140; next morning the pulse was 100, and subsequently it never was more than 90. She felt quite well the morning after admission. Mitral bruits were audible. Since discharge: I have heard from her this week. She has continued to have the attacks about once a month; never suffering from cardiac failure, and only feeling poorly for about two days. Miriam, 31, April 25th to May 1st.

I have only come across four cases, including the one mentioned above as admitted into Miriam; three of them were women. All were neurotic; one of them gave the same history of trouble in her mother (? heredity). This last patient had suffered for eight years; refused admission, but came up daily to the surgery for nearly a fortnight, and was interesting from the fact that being unable to take digitalis, the administration of strophanthus (ten minims of the tincture) with eight grains of each of the three bromides, certainly improved her pulse for a time. I have been unable to follow up the case. Various remedies have been suggested, such as abdominal compression and the application of electricity; all are disappointing. The tonic treatment is, on the whole, most satisfactory, and this seems to suggest a nervous origin. One other point is, that as a rule, they improve in general health greatly as a result of graduated exercises, on the lines of the Nauheim treatment (which I shall discuss later). The male patient mentioned above, was recommended to begin with a pair of light wooden dumb-bells. The exercises were of such a nature, that when he began, only one movement of each particular group of muscles was allowed. I continued to hear of him for four months, and during that time he was putting on weight, and had had only one attack. My last post-card was returned. Thinking it over, I believe he was a nicotine heart. In Clifford Allbutt's book, a case is quoted, in which the patient eventually took to riding a bicycle, with much benefit to himself. Under these circumstances one can at least say that the treatment is encouraging. The great point to remember is, that any over-exertion or strain will bring on an attack.

Bradycardia, I will dismiss in a few words:—

1. If bradycardia is associated with vertigo and syncope you have very strong evidences of myocardial degeneration. And you will be wise if you give a grave prognosis.

2. In another class, there are evidences of increased blood-pressure.

3. If the case does not fall under the two previous headings, examine the eyes and be sure that you can exclude cerebral disease.

4. And lastly, a pulse of 50 is in no way uncommon, and a pulse of only 30 has been found in every way compatible with a sound constitution and longevity.

Syncope.—At the risk of hearing you remark that I am delivering a first-aid lecture, I have next set down syncope for your consideration. Briefly, there are two varieties of fainting attack:—

Firstly, there is the syncope which too often is the sad end of that patient who has survived—after many days—the perils of this protracted illness, and finally, as a result of his temerity, a sudden strain, excessive exercise, or what you will—the weakened myocardiam has gybed at the strain which has been thrown upon it. To this state

of affairs there is but one reply—and that reply is in the form of an injection of ten minims of strychnine.

The syncope of the overcrowded room, on the other hand, is not primarily a cardiac failure but is due to a fall of arterial blood-pressure, resulting from cutaneous and splanchnic vaso-dilatation. The treatment is to stimulate the heart to contract by unloading the right ventricle. This is brought about by setting up deep inspirations, with cold douches, smelling salts, etc.

The "weak heart," so-called, of certain individuals who are liable to attacks of pallor and faintness, is another degree of this variety of syncope. The tendency is to fly to the brandy bottle upon each and every occasion, and you will be successful if you can prevent it. The Nauheim treatment is frequently a great success with these patients.

"*Irritable heart*" is the name applied to another form of disorder you will meet with. And it is interesting because the disorder seems to bridge over the interval which lies between the transient disturbances we have been describing and the province of structural incapability for work which we shall consider later. Irritable heart, then, is a curable disease, the product of a multitude of conditions. The story is practically always that of a young man who comes for advice about his heart. He feels it thumping at night and it gives him pain. In many of these cases no doubt you will obtain a history of over-exertion. 'Varsity men who have taken up rowing to an extent which has taxed their capabilities far beyond the high water-mark of their previous school days, complain of the trouble. But perhaps the most common applicant for your advice will be from among that tide which evening and morning ebbs and flows into this metropolis, and who, after five and a half days spent between an office stool and a City restaurant, retires to spend one short afternoon in an outburst of muscular exertion. It seems as if the heart became excited as a result of the extraordinary call for its activity which is made once in every seven days.

No. 2.—C. C., male, æt. 24. A clerk in the City, hours from nine to seven, only takes half an hour for lunch. No exercise at all until Saturday afternoon, when he plays football; recently has felt poorly after it, especially on Sunday morning. Complains of occasional pain in the chest with palpitation. On examination: Heart 120, subsequently slower; on most visits about 90; occasionally misses a beat; no bruits. No evidence of enlargement. Advised to give up football and smoking. Diet. Only came up for two months. Heart was still irregular, but he felt much better. Arsenic and iron.

The treatment is important. Rest in bed for a month at least. Alcohol and tobacco must be forbidden. Tea must be milk-tea, that is to say, milk simply flavoured. It is better to forbid coffee; cocoa is an excellent substitute. Drugs will in all probability be a minor consideration. As the patient is getting about again arsenic will prove invaluable. And it is as well to remember that the stimulating effect of arsenic is best obtained with a dose of three minims, three times daily before food (five-minim doses are distinctly large for such cases). The first week out of bed will be an important one, and an intelligent nurse, who knows how to feel a pulse intelligently, especially on patient's return to bed in the early evening, will indicate to you whether the barometer is rising or falling.

The return to the usual occupation must be gradual, and any form of violent exercise forbidden for fully six months. After all, prevention is better than cure, and there is no doubt that the present-day manner in which so many City men obtain their exercise by great bursts of energy, is much to be deprecated. One would suggest that the exercise be more evenly distributed by the daily observance of simple laws of health. Five to ten minutes night and morning, with nothing but the first six exercises of the Aldershot physical drill, will ensure that when the weekly burst of exercise does come, the unprepared heart is not thrown into a tumult by a Herculean task.

I have made no mention, you will notice, of the so-called "Sandow treatment." Last February, a lad of sixteen, came up from Chatham to see a "hospital specialist," and as usual found his way to the consulting room of the assistant house-physicians. He gave a history of having become short of breath, about nine months previously, and after "advice," I know not where, had started the "Sandow treatment" to improve his wind. It was indeed hard to tell the father that his son's heart was in an advanced state of disease. I remember that I gave him two years. In this condition, for eight and a half months, and those months at the age of puberty, this lad had performed the usual exercises. He told me that the usual way was to perform each exercise until the particular group of muscles feel absolutely exhausted. After twenty minutes of this he took a cold bath. I leave you to draw your own conclusions.

Closely allied to irritable heart and frequently confused with it, is *soldier's heart*, described by Da Costa among recruits of the American army. As a class they are town bred men who had led quiet lives and who suddenly have thrust upon them all the rigors of a military training.

The rest in bed which we prescribed for the cases of irritable heart is of little effect, and even with this rest œdema may be present. Briefly speaking, the temporary dilatation of the functionally disordered heart has become permanent and we are dealing with an organ suffering from the effects of mechanical strain. The microscope, too, will give us evidence of degenerated muscle-fibre.

Organic Disease.

Myocardial degeneration.—Of fatty and fibroid heart you will see many examples in this neighbourhood, and among the causes of disease the following I suppose will occur to you: Chlorosis and the allied anæmias. Toxic conditions arising from alcohol, nicotine, and the specific fevers, especially diphtheria. Inflammatory conditions, such as syphilis. The impairment of repeated or prolonged strain in an unhealthy subject, and lastly deficient blood-supply owing to

diseased coronary arteries. I propose to take only those varieties which call for special treatment.

A. The fatty heart of anæmia. It was only after attention had been drawn to results of the treatment of chlorosis by prolonged rest that failing heart was recognised as the immediate cause for the distressing symptoms of chlorosis. There seems to be now no doubt that the whole trouble may be put down to the toxic influences of constipation, and as a result of this poison changes take place in the cardiac muscle, which have been demonstrated on the post-mortem table, and which during life give rise to dilatation, with diffuse, irregular and feeble impulse. There is no doubt that careful observation of the size of the heart from day to day in chlorosis, will give you an earlier and more accurate ndication of the progress of your patient than *any amount* of mathematical excitement concerning the colour, size, shape and abundance of the various varieties of blood cell. Keeping this point in view, the absolute rest of the patient is to be continued until such a time as the heart shall have regained its normal size, and the isappearance of any bruit, if that were present, indicate that the erratic workings of the papillary muscles have given place to contractions co-ordinate with the ventricular systole. As a result of the disordered action of the heart there is reflex disorder of the organs supplied by the vagus, and prominent among these are the gastric troubles which have received the name of "anæmic vomiting." Rectal feeding in such conditions may be added to the general treatment above mentioned.

B. The next variety of degenerated heart is that arising from over-indulgence. Wealthy landowners and City aldermen will be numbered among your patients. Into the same clinical group come the cases of those who lead sedentary lives. Unmarried ladies with incomes, shopkeepers and clerks. I have brought this group before you, because it is the class par excellence benefited by that variety of treatment which is practised at Nauheim. You know the patients and their symptoms. Age, about middle life; a tendency more or less to "embonpoint." Liable to indigestion, palpitation and shortness of breath.

It has only been during the past twenty years that the value of graduated and systematic muscular exercises has been appreciated. Oertel introduced these in the form of degrees of hill climbing. Briefly, the advantages claimed are, that there is an increased blood-flow to the right side of the heart. The respiratory movements are deepened, the delivery to the left heart is accelerated, together with the output. The chief point to remember is, that the result of the exercise should be a slow and complete expansion of the lungs, with no acceleration of the breathing rate. I have not been fortunate enough to see the town, but I understand from those who have been there, that the town is laid out for the benefit of patients, with gradients of different lengths and severity, which are attempted, in order, as the individual becomes stronger. It was left for Schott, of the same town, to substitute physical exercises for hill climbing, where the latter was impossible. The exercises known as resistance gymnastics are performed as follows: the patient is clothed in loose garments, and whilst breathing deeply, is instructed to make various movements, involving different groups of muscles, which are resisted by a trained assistant. After each movement there is an interval of rest; all movements are made slowly and deliberately, and when the treatment is first begun, only a single group of muscles is exercised at one time; the patient first of all lying upon a couch, subsequently he is allowed to sit up, and later still to stand and support himself whilst performing movements of the lower extremities. No clubs or dumb-bells are permitted. Movements of the trunk are taken last of all, that is to say, only some time after the treatment has started.

I have put down a few points to remember about the treatment:—

1. No patient suffering from weak heart should be allowed to start any form of muscular exercise who has not been under your personal observation for six months. To this rule there must be *no* exception.

Cases of sudden syncope and death are by no means unknown.

2. The daily examination of the heart is at first essential, and later should take place at regular intervals.

3. Patient's weight is to be taken weekly.

4. Should the result of the exercise be an acceleration of the respiratory rate or any appearance of flushing or pallor, every hour spent in muscular exertion is spent in driving nails into the man's coffin.

If such should occur, your treatment is plain; the patient must return to his couch or chair and possess his soul in patience.

In addition to the exercise, bathing combined with massage is also practised at Nauheim. The springs containing mineral salts and free carbonic acid gas are at a temperature of 100° F. In bad cardiac cases, the bath is given at a temperature of 95° for ten minutes, and the period of immersion is increased during the course of treatment to forty minutes with a temperature of 85° F. The effect of the bath is usually to reduce the pulse from five to ten beats per minute, and besides this it is claimed that the heart diminishes in size as the baths are continued. All authorities are agreed that in many cases there is marked and permanent improvement after a term of residence at Nauheim.

Dr. Sansom, reviewing the "bathing treatment" in Allbutt's Medicine, is inclined to ascribe the results almost entirely to subjective sensations. It seems to me, however, that just as we saw a temporary disorder of the vaso-motor system may give rise to most profound functional distress, so this bath treatment may, by exercising the vaso-motor mechanism, assure that vaso-dilatation and constriction respond in proper sequence and order, to the various alterations of blood-pressure produced by even slight changes in the central cardiac mechanism.

No account of the Nauheim treatment, however brief, would be complete without some reference to diet, as the latter factor is, as always in cardiac trouble, of extreme importance. The chief point insisted on is that fluids

shall be limited. The amount of water per diem, including that contained in the cooked food, is fixed at thirty-five ounces. Patients are permitted a small cup of tea morning and evening, about half a pint of hock or claret with the mid-day meal, of soup or beef-tea four ounces, and of water not more than fifteen ounces. With regard to solid food, the relative proportion of proteid should be high. Proportion: fat, carbohydrate, proteid 4—13—20.

Of bread	℥iv. to v.
Of meat or fish	℥vi. to vii.
Chicken	℥v.
Fresh or cooked fruit ...	℥iv. to vii.
One or two eggs.	
Butter or cheese, salad.	

You can quite understand that such patients as the above do not often come up for treatment to London hospitals. If he can get about at all, the Boro' bread winner is at once to his trade of necessity, and too often to his cost. I had the advantage of watching one patient for some time, but here again treatment as an out-patient is very different to daily observation in the wards.

No. 3.—C. S., æt. 38, a grocer. All his life he has lived in London, and in the grocery business. He takes practically no exercise. Recently has been getting stouter, eats well, beer drinker. Quite recently has moved his shop to where there are more stairs, and he thinks that the continual up and down during the day is the cause of his trouble. Breathlessness at times, slight pain in the chest, anxious about himself. Saw him in February; no œdema, heart-sounds somewhat indistinct, not rapid. Same trouble in April. Fatty heart diagnosed. Exercises advised. His wife was instructed how to resist his movements. Dieted. No medicine at all except a laxative. He continued to improve in every way. In August he had actually gained in weight, was very cheerful, and had great confidence in the system. No breathlessness at all or pain. In October pneumonia, which proved fatal. For five months, however, continuous improvement was noticed.

C. The other variety of myocardial degeneration I will mention is that due to alcoholism. The treatment of this class of disorder will be dealt with under the heading of "wrecks" at a later period, because they form a group whose usefulness is over, and for whom one can only provide a temporary repair. The great point to remember about alcoholic myocarditis is the great rapidity and extent of the failure. Although your patient has been in bed a fortnight or more, the œdema, the incessant cough, the anxiety of dyspnœa are still becoming more troublesome, and in eight weeks from the time when he took to his bed all will very probably be over.

(Case 24, John 15, September, 1903.) W. B., æt. 42, old army gunner, 7 years in the service. India. Malaria. Discharged at the age of 28. Has since been an ostler. Takes "plenty to drink." June 15th, breathlessness first noticed. August 1st, gave up work, bronchitis troublesome. September 5th, went to Margate for a change. September 9th, not so well, œdema started, bed. September 12th, return to London, œdema still present. September 15th, admitted into John. Venesection performed on two occasions. Digitalis of no use, went steadily downhill. Death on November 6th. Post-mortem, valves healthy; pale, fibroid heart, weight 22½ ozs. Anasarca, embolism of superior mesenteric artery, infarction of lung.

Angina Pectoris

A disturbance of the cardiac function, which is (*a*) sudden in its attack, (*b*) of an agonising character (*c*) attended by dyspnœa, and (*d*) by a horror of impending death. The malady, as you know, is divisible into two groups.

(*a*) Angina pectoris gravior, which is again subdivided into—

1. Primary cardiac angina or syncope anginosa.
2. Secondary cardiac angina.

(*b*) Angina pectoris vaso motoria or pseudo angina.

A (1). Syncope anginosa. In this variety the evidence of the most-mortem table points to disease within the heart itself.

Of 91 fatal cases, in only seven was there no organic disease of the heart or its nutrient vessels. Of the remaining 84—

In 51, the coronary arteries were affected.

In 13, the heart muscle alone. (Sir Douglas Powell.)

Again, of 148 autopsies in which coronary disease was found—

In 128 there was obliteration or stenosis.

In 64, both right and left vessels were affected. (Huchard.)

This is no place for discussion as to pathology.

There are a few points to think of, as regards diagnosis:

1. The age of the patient, 40 to 60.
2. Nearly always a male.
3. Very frequently angina is hereditary.
4. The occupation of the patient. Professions in which there is frequently nervous strain and high arterial blood-pressure. Finance, politics, medicine.

The symptoms are too well known to bear repetition; remember, however, that the patient suffering from syncope anginosa, is collapsed, lies still, and does *not* rock about with the pain. The attack often arises without obvious cause. The following case is of interest.

A relative of one of our staff living in the north of Scotland had suddenly become liable to attacks of pain in the chest; there had been two attacks; no cause had been found. Owing to the anxiety of the wife, a consultant was summoned from London. The examination over, as the physician was leaving the room, the patient called out cheerily to his wife: "There you see, Dr. X. has come all this way, and found nothing wrong with me." At that very moment he fell back in the bed. Syncope anginosa had claimed another victim. The consultant subsequently told the widow—"I was just going to tell you not to worry about your husband." Such an instance may remind you that you cannot be too guarded in venturing a prognosis.

A (2). The other variety of cardiac angina is termed secondary, and into this sub-division come cases of anginal pain which arise as a result of vaso-motor disturbance in a heart already diseased. Such conditions are familiar to you in the medical wards, where patients suffering from fibroid heart, aortic disease, or mitral obstruction, are liable to repeated anginal seizures until one of greater severity has given a last long relief.

Case 22.—E. K., male. Admitted into Stephen on April 27th, 1904, in an extreme condition of shock. He had been suddenly taken in Fenchurch Street with an attack of pain in the chest, which caused him to fall down. For about two hours he lay in a medical man's consulting room, still very collapsed, and was in such a condition admitted to Guy's. A City wine merchant by occupation, well-to-do, heart enlarged, no bruits. Has had breathlessness for the past six months. Vomit examined, contained nothing abnormal. Oxygen and nitroglycerine relieved him. November 16th, 1904: still liable to breathlessness, no further attacks of angina.

Case in Luke, May, 1902.—A man was admitted for stricture. He was distinctly fat, but said he enjoyed good health. One afternoon he was allowed to walk and had only gone about six yards when he called out with pain in the chest, fell down and expired almost before he could be put back to bed. Post-mortem, fatty heart, no other disease.

The following case is also of interest as being typical of this variety of angina. It is recorded by Anstie:—

A boy, aged eleven, who had always been a healthy child, and not in any way backward for his age, either at work or play, stopped suddenly whilst running, cried out with pain in the chest, and expired. At the autopsy he was found to have marked stenosis of the aortic orifice. The heart had apparently stopped in a condition of diastole.

Treatment (*a*). For the acute attack.—Every first year's man knows what amyl nitrite is used for. Personally I consider that the subcutaneous injection of three minims of the liquor trinitrini, B.P., is more efficacious and lasting, besides being almost as rapid in its effect. During the short interval of waiting for the effects of the injection, oxygen should be given.

Other points to remember:—

1. Prop the patient up in bed and have him supported.
2. Tell him not to attempt to talk; to pass his water into the bed if he wants to, as this will probably be his first complaint.
3. Tell him also to belch up the wind if he feels his stomach is distended.
4. Bedclothes should be dispensed with.
5. If in the course of fifteen minutes he is no better, give another two minims of trinitrini hypodermically.

(*b*) As he recovers, don't let him do anything. Put on the blankets and apply hot water bottles. Give him to sip equal parts of brandy and water hot. On no account give strychnine. If you are afraid of collapse continue your oxygen. If the pain continues in a less degree during the next half-hour, give him a quarter of a grain of morphia subcutaneously and he will not only be relieved but also reassured as to his general condition.

During the next week it is your duty to let the man understand that any exertion, however slight, on his part, may bring on another attack. With regard to diet, a limited amount of fluids with food containing a relatively large amount of easily digestible nitrogen is indicated.

Drugs.—A mixture containing nitroglycerine in a diuretic mixture is best for two or three days, and this should be followed by potassium iodide, which may with advantage be combined with small doses of arsenic. If you find it necessary to continue the nitroglycerine, do *not* give it in the form of the tabloid, for you must remember that the word "Angina," like "Cancer," is spoken of with bated breath in many an English household; and everyone knows what those little chocolate drops are given for. Do not forget that the fear of another attack, and the knowledge of your patient that life is but hanging by a thread, is the great difficulty with which you will have to contend in anginal cases. Far better to keep such knowledge from them as long as possible. Tell the worst to any of the friends who are sensible. With the same object in view, namely, a lowering of the general blood-pressure, the use of erythrol tetra-nitrate has been recommended. I have had no experience of its action. The nightly administration of the official mercury pill, followed by a wineglassful of Hunyadi Water in the early morning will assist in the same way by ensuring a copious and *comfortable* evacuation of the bowels. There is no need to consider prognosis. You know of its gravity. One might add, however, that in secondary cardiac angina, the presence of mitral regurgitation seems to act as a form of safety valve, and the sufferer is unfortunate enough to survive more attacks.

Pseudo Angina, I shall not discuss. Many of the symptoms giving rise to it we shall treat of in mitral trouble.

(*To be continued*)

Appointments.

Civil.

REY, JULES F., M.R.C.S., L.R.C.P. Lond., L.D.S. Eng., has been appointed House-Surgeon to the Royal Boscombe and West Hants Infirmary.

ROPER, R., M.R.C.S., L.R.C.P. Eng., has been appointed First Assistant Medical Officer at the St. Marylebone Infirmary, *vice* Mr. Ward, resigned.

TURNER, H. STANLEY, M.R.C.S., L.R.C.P. Lond., has been appointed Registrar to the Central London Ear and Throat Hospital.

TYSON, WILSON, M.B., B.C. Camb., has been appointed Surgeon to the Lowestoft Hospital.

WORTS, LEWIS, L.R.C.P. and S. Edin., has been appointed District Medical Officer of the Leighton Buzzard Union.

Sport.

FOOTBALL FIXTURES.

Saturday, December 3rd.
G.H.R.F.C., I., v. Richmond, away.
II., v. Old Millhillians, away.
III., v. N.C.S. Old Boys, away.
G.H.A.F.C. I., v. Beckenham, home.
II., v. Croydon Park II., away.

Saturday, December 10th.
G.H.R.F.C., I., v. Northampton, away.
II., v. African Bank, home.
III., v. Old Whitgiftians, away.
G.H.A.F.C., I., v. Kenley, home.
II., v. Normanhurst Druids, away.

Saturday, December 17th.
G.H.R.F.C., I., v. N.C.S. Old Boys, home.
II., v. Norwood, away.
G.H.A.F.C., I., v. South-Eastern College, home.

HOCKEY FIXTURES.

Saturday, December 3rd.
G.H.H.C., I., v. Bromley, at Bromley.

Saturday, December 10th.
G.H.H.C., I., v. R.M.C., home.

Rugby Football.

GUY'S v. OLD MERCHANT TAYLORS.

The above match was played at Honor Oak Park on Saturday, November 19th. There was a good attendance of the public, but the absence of support from the senior men and residents was again very noticeable. Guy's were minus the services of McEvedy and Alcock in the three-quarter line, but Ward made his reappearance in the forwards. Guy's during the first half had the advantage of a light wind behind them. Play in opening stages settled in mid-field. Our forwards were shaping well and heeled smartly. Louisson and Webster opened up the game in promising style. Digby received from Webster and feinting to pass worked his way through the opposing backs in brilliant fashion, but at the last moment spoiled a superb effort by selfishness. Guy's still continued to have the best of matters. Stringer found touch a yard from the corner flag with a magnificent kick. From the ensuing line out Webster secured and scored. J. P. Jones with a well-judged kick converted. On the re-start Digby again distinguished himself by making one or two brilliant runs, but, as before, threw away golden opportunities by selfishness. J. P. Jones put in some sterling defensive work; his line kicking being of great service. Good passing by the backs enabled Stringer to score from a fine opening made by Digby. C. E. H. Jones failed with the kick. The remainder of the first half went entirely in favour of Guy's.

During the second half the Taylors played a much stronger game, and for the first quarter of an hour, repeatedly threatened our lines. The defence, however, was very solid, Louisson, Digby, Jones and Husbands being conspicuous. Good forward rushes in which Saunders, Ward and Mullins were prominent removed play to the other end of the field. Stringer made one or two fine dashes. Just before call of time, Louisson secured from a scrum, and running round the blind side transferred to Stringer, and that player turned a smart piece of play to account by scoring a splendid try. Jones failed with the kick. Final score: Guy's 11 points, O.M.T's. nil.

Remarks.—The play of the forwards was a distinct improvement on their previous performances. The heeling was much cleaner and the tackling in the loose more effective. There was a slight falling off in the scrum work during the second half, and in consequence our opponents secured the ball more often. Saunders was good in the loose, but must learn not to kick so hard. Digby did some fine things at three-quarter, but must remember he has other three-quarters playing with him. Both Jones and he might improve in the taking of their passes. Husband's fielding of the ball also shows room for improvement.

Association Football.

GUY'S v. SURBITON HILL.

On Saturday, November 19th, we played this match at Honor Oak, and managed to win by 3 goals to nil. Surbiton kicked off, and our forwards getting the ball at once pressed hard for some time and several times had bad luck in not scoring. Our first goal came from a run down the wing by Pedrick, who centred to Barber, and the latter scored with a low drive. Soon after this Barnett headed a second from a centre by Wragg. In the second half, play was more even, but we managed to score again after some nice combination by our right wing.

Wilson and Jones at back both played well, and Pedrick was the best of the halves. Team:—

Guy's.—C. A. Wood (goal); A. G. Jones and A. R. Wilson (backs); P. V. G. Pedrick, A. F. W. Denning, L. H. Frankenburg (halves), E. Wragg, H. Barber, D. J. Wearing, E. Barnett, and E. N. Plummer (forwards).

GUY'S v. HASTINGS.

This match was played at Hastings, November 23rd. From the kick-off Plummer got the ball, and passing out to Wragg the latter centred, and Barnett opened our score in the first minute of the game. Our forwards were now playing well together, and before long Wearing scored our second. After this Hastings had the best of the game, and Wood had several shots to stop. Our

opponents' right wing made some good runs and centres, and twice in quick succession they managed to score. Soon after Barnett put us ahead again, and at half-time we led by 3 to 2. On resuming we had matters pretty well our own way and we scored twice more and thus won by 5 to 2. Team:—

GUY'S.—C. A. Wood (goal); A. G. Jones and A. R. Wilson (backs); P. V. G. Pedrick, A. F. W. Denning, and L. H. Frankenburg (halves); E. Wragg, E. N. Plummer, D. J. Wearing, E. Barnett, and S. A. Piper (forwards).

REMARKS.—The forwards showed improvement in their combination, especially in the first half, but the shooting was far from being good.

Guy's Hospital Hockey Club.

GUY'S v. TRINITY (CAMBRIDGE).

Guy's met defeat at the hands of Trinity at Cambridge on Wednesday, November 16th, by 4—3, after a very close game. Guy's went clean away at the start, and scored twice in quick succession from Wells and Davies. Dryland added a third after twenty minutes play, and Trinity scored through Andrews just before half-time. After this, the entire Guy's team seemed to collapse, with the notable exception of Archer, who was splendid, and Trinity added three, (Andrews 1, Chase 2) in the second half. Moyle was distinctly good in goal, except once; he must get rid of the ball at once, and to the side, and would do well to learn to trust to his feet for this purpose. Ticehurst centred very well, and if he can increase his pace, should prove very useful. The deterioration in the shooting of the forwards, was out of all proportion to the slight improvement in their passing. The defence was all over the place; not a single foul was claimed throughout the game, which was unique in this respect, and we hope in others also.

GUY'S II. v. ROYAL MILITARY ACADEMY II.

Played at Woolwich, Wednesday, November 30th, on a very slippery ground, the second did wonders against the above team, eventually winning by 7 goals to 2. Guy's scored in the first ten minutes, after which there was a spell of even play in mid-field. Ticehurst then added another, and Clarke put in a good shot, but was ruled "off-side"; but he soon added another, and the Hospital led at half-time by 4 to nil. After the interval, Woolwich played up hard and scored twice in rapid succession, but Guy's pulled themselves together and scored three more, one through Clarke and two through Ticehurst, the last one being a very good shot. The latter was distinctly good, and Clarke was much improved at outside left. Thomson was good at left-half, Rankine worked hard throughout, but at times lacked dash; Brookhouse improved greatly during the game; Barker, at back, was most useful, but lacks power; Decks was good, and Moyle's presence in goal seemed to divert the aim of the opposing forwards. He is improving with his feet.

Review.

The price of books submitted for review should in every case be stated.

An Introduction to Dermatology. Norman Walker, M.D. Third edition, pp. xvi.+284. (Messrs. J. Wright & Co., Bristol). 9s. 6d. net.

It is a pity that Dr. Norman Walker should have spoilt this book by the introduction of twenty-two coloured plates, which obviously must be of the crudest description. Pictures of skin diseases are notoriously difficult to obtain, and can only be satisfactorily produced in an *edition de luxe*, such as this work does not pretend to be. Plate xiii. represents a hand, the lesions on which do not resemble scabies; and the student will be disappointed if he ever expects to find the *apple jelly* nodules so distinct as they are displayed in Plate xxxvii.

For the text, however, we have nothing but praise; the photographs are excellent, and there are many diagrams of microscopical sections.

Unna's classification is followed, and full details are given as to the symptoms, treatment, and distribution of the lesions—their actual nature being difficult to learn from written descriptions, are described less minutely. "Eczema is the term commonly applied to any wet or scaly inflammation of the skin, of the cause or nature of which the observer is ignorant," and the truth of this statement few will deny; while the fact that ἐκζεω means to boil over does not assist much at a definition. The derivation of many words are given, and the translation of *lesion* into *a honeycomb* involves a most unpleasant comparison.

We learn that in Paris and some of the London Hospitals, out-patients afflicted with scabies are treated in sulphur baths before leaving. Either they must be few in number or the diagnosis must be rarely made.

Only six pages are devoted to syphilitic lesion, and the author regards psoriasis "as merely the extremely dry form of seborrhœa."

Dr. Norman Walker has embodied the Edinburgh teaching in a book which will be found useful by any student in search of a "Skin Book."

Births.

CAZENOVE.—On November 10th, at Long Sutton, Lincolnshire, the wife of William Reginald Cazenove, M.R.C.S. Eng., L.R.C.P., of a daughter.

WALKER.—On November 28th, at Hook Norton, Banbury, Oxon., the wife of T. Malcolm Walker, M.R.C.S. Eng., L.R.C.P., of a daughter.

Death.

POWER.—On October 29th, at Hucknall Torkard, George Edward Power, M.R.C.S., L.S.A., aged 55.

ED. R. E.

GUY'S HOSPITAL GAZETTE.

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CONTENTS.

	PAGE.
Passim	513–515
Some cases in which Blood was passed from the Rectum. Clinical lecture by Dr. W. Hale White	516–522
Papers by Guy's Men	522
Nurses' and Students' Choral Concert ...	522–523
To Intending Buyers	523–524
Change of Address	524
Pass List	524
Appointments	524
On some rare forms of Jest occurring in Lecture Rooms	525
The Treatment of Cardiac Disease... ...	526–530
See also Tables	532–535
Reviews	530–531
Notices	531
Specialities	531
Sport	536

Passim.

CHRISTMAS is here at last. A few days ago the spirit of unrest became general. Lecturers have bidden us farewell with a relief that they did not trouble to disguise, and we have not wept at their departure. Sisters have forsaken their wards for the purlieus of Covent Garden. Residents have marched solemnly and several times round the College quadrangle, treating the Boro' to a more terrible selection of concerted noises than even that abode of many sounds has ever achieved Pianos tinkle from the wards and the silver-throated nurse is occasionally heard to carol unashamed, while around her, under the deft hands of dresser and ward clerk, the ward takes on a geometrically sylvan aspect.

WE publish here the official programme for the coming week :—

Dec. 26.	Nigger Troup on tour and Out-patients' Tea.	
Dec. 27.	Lazarus Concert	5.0 p.m.
	Residents' Theatricals in Court Room	8.15 „
Dec. 28.	Job and Lydia	5.0 „
	Residents' Theatricals ...	8.15 „
Dec. 29.	Ruth and Barnabas Concert...	3.0 p.m.
	Martha Christmas Tree ...	3.30 „
	Luke and Charity Concert ...	5.30 „
Dec. 30.	Naaman and Dorcas Concert	6.0 „
Dec. 31.	Astley Cooper Concert ...	7.30 „
	Ceremony round Thomas Guy's Statue	12.0 „

AFTER all, the most satisfactory event is the crowning and final item of the above programme. There is all the dramatic importance of a finale to be considered, to say nothing of the eternal fascination of the clean slate. The ever hopeful outlook of January 1st, is one which, with care, can be preserved for a much longer period than is generally supposed, if one is complacently inclined, and will shut one eye at the insidious blurring of the picture. In any case the comfortable glow of such a vision lasts long enough to render our ultimate descent into the commonplace not so harrowing a process as it might otherwise be.

THE Physical Society's meeting on Saturday evening last was a most satisfactory one, and the results fully justified the Secretaries in following up last year's discussion of Cancer, with a similarly arranged discussion of Gout. The evasive nature of the subject had not deterred any of the four prime movers from a fairly exhaustive research along the particular lines

marked out for them, but, none of these gentlemen showed much fight, when, bereft of documentary support, they were called upon to face insistent and damaging criticisms. Another, and a more important drawback was the manner of delivery of these same dauntless four. Speech-making is one thing, paper-reading is another; and while it is ungracious to criticise an inexperienced author on the ground of obscurity, we feel justified in lodging a mild protest that many of those present should have experienced any difficulty in following the arguments of the papers on account of occasional inaudible reading. We have no wish to carp, but in view of the importance and interest of the meetings of the Physical Society, we feel that they should take steps to set right so important a matter as this. The attendance at the meeting was good, and the number of junior men who were present is a sign that bodes well for the Society and for the Hospital.

It is not often that novelists give us anything like an adequate description of life in a hospital ward; their attempts are apt to be conventional and highly coloured, or else they evince extreme unwillingness to credit doctors and nurses with the ordinary instincts of humanity. It is, therefore, to say the least, refreshing to come across such a book as "The Grey World," by Evelyn Underhill, but its manifest excellence, and the insight it shows in matters of interest to hospital folk, tempt us to quote from it at some length. In the first chapter, a small boy, a bit of "slum-reared humanity," lies dying of typhoid fever in one of the wards of a certain St. Nicholas Infirmary; where the—

> "... uncomfortable cleanliness and a certain martinet method of kindness were not pleasing to a taste that had been formed amidst the homely squalor of Notting Dale ... Being too weak to make noises for himself, he would have liked someone else to take on this agreeable duty, but that never happened, and the silence and good behaviour were harder to bear than all the pains of his illness .... Happily, however, there were occasional oases to be found even in this desert of hygienic decorum. They were called visiting days, and they happened twice a week. At these times his mother came to see him, bringing with her local perfumes and phrases that raised his dormant nostalgia to the pitch of acute desire. Her homely figure, formed of misplaced curves, and the drooping assurance of her hat, cheered his spirits as they entered the ward, and to the manifest disapproval of the nurses, gravitated to the side of his cot."

Here again is an epitome of the events which are fairly common in the experience of many of us, and which here led to the above small youth's decease:—

> "After some weeks of luxurious boredom, and when he was supposed to have commenced a normal and satisfactory convalescence, his mother yielded to a maternal impulse and involuntarily set going the scene-shifting machinery of death. The special lever which she selected took the form of a currant bun."

In the scene which follows, the intense description of the pains of dissolution in a small boy of some ten years may vex the mind of the austerely scientific, and to those whose horizon is limited by the chart and the bed-letter, may seem like an unwarrantable exercise of the imaginative faculty in realms of purely clinical interest. For such as these, should they continue to read the book, there will be consolation in the author's contrasts perhaps; for though the keynote of the book is æstheticism, yet the hero's name is W. Hopkinson, his father is a wholesale tailor, his some-time mentor a Jewish lady of generous proportions and doubtful age, while there is an exhibition of that "luke-warm preference" condemned by Stevenson as too often passing for love, which should satisfy the cold blooded common sense of the most uninteresting. From every point of view the book is one of the best written and most stimulating novels that has appeared for many a month.

The *National Review* for December contains a most interesting article on "A visit to Sasebo, the Japanese Naval Hospital," by a well known Guy's man, Dr. Francis E. Fremantle. Written in a light and suggestive style, this article makes it abundantly clear that, with one or two exceptions of a rather academic nature, the Japanese have little more to learn from European surgical methods, while in matters of dicipline and routine it is doubtful whether their example can be improved upon. Dr. Fremantle points out that the naval surgery of the present war is unique in "that 90 per cent. of the cases of ordnance

wounds are inflicted by shell and not by bullet. Here then, for the first time in history, the science of shell-wounds is being studied under good modern conditions. For in South Africa hardly 5 per cent. of wounds, even early in the war, were inflicted by shell, and these were scattered up and down the country through a dozen different hospitals, so that a concrete study of their peculiar feature was impossible. The report, therefore, of the Japanese Navy at the conclusion of the war will make a definite addition to surgical science." The essential difference between bullet and shell wounds is laid stress upon; for, whereas the former, in a great many cases, are comparatively trifling when no important structure has been damaged, the latter are almost invariably severe lacerations further complicated by the fact that the explosion frequently produces serious burning. Keenness and proficiency is apparently the rule and not the exception among the Japanese nurses, in whose ranks are many ladies, titled and titular. It is interesting to read under this head, that at a meeting of Japanese ladies at the Red Cross Society on July 1st, three of these same shook hands with Dr. Fremantle.

The Director-General of the medical department of the Japanese Navy is Baron Sareyoshi, who was educated at St. Thomas's Hospital, and is a Fellow of the Royal College of Surgeons of England. In the main the Japanese surgeons have derived their inspirations from German professors, and show "the faults as well as the virtues of the German methods." Dr. Fremantle criticizes their system of centralising responsibility in the chief surgeons, who perform most of the operations and leave little to their less experienced colleagues. In their precautions against sepsis also the islanders are ultra-modern. Such is their "confidence in their ability to exclude all sources of contamination from a wound, that they employ no antiseptics, but to this end they have to boil even the tap-water in which they wash their hands. Experience, however, seems to show, in Japan as in England, that this confidence is not justified. One of their hospitals, at least, has had more than its fair share of suppuration. In other words, the Japanese, in this as in most departments of modern knowledge, have adopted the most apparently thorough method known in Europe; and they lack as yet the experience which may show them, as it has shown us, where it is defective and must be helped out by the older method, the use of antiseptics." Dr. Fremantle is to be congratulated on writing an article which will be read with the greatest interest by both medical men and nurses.

The next meeting of the Debating Society will take place on Saturday, January 7th, when the subject for discussion will be "The Higher Education of Women."

We should like to call men's attention to the Postman's Fund, subscriptions to which are solicited by the Librarian. This is one of the many thoroughly deserving funds which are annually raised.

We are requested to state that the next volume of the Guy's Hospital Reports is in the hands of the printers, and will be obtainable before the commencement of the new year.

It was the opinion of the Gazette Committee that our readers would desire no better Christmas picture than the portrait of the Founder which accompanies the present number. The Committee propose to inaugurate a series of portraits of Guy's celebrities, and the selection of the first in such a series was free from any embarrassment. There are several portraits of Thomas Guy extant, that from which the present reproduction is made being by Vanderbank, painted, as will be observed from the date on the picture itself, in 1706. The original, which hangs in the dining-room of the Superintendent's house, was presented to the Governors some fifty years ago by Mr. Butterworth, one of their colleagues. This is the first attempt that has been made to render the features of Thomas Guy as familiar as his name, and no pains or expense were spared to secure a result worthy of the subject. We modestly believe we have succeeded.

Some Cases in which Blood was passed from the Rectum.

CLINICAL LECTURE BY DR. W. HALE WHITE.
November 12th, 1904.

GENTLEMEN,—We happen to have had in the wards lately some good examples of the passage of blood from the rectum, and I think our time will not be wasted if this afternoon we discuss them.

The first case was that of a middle aged woman, who suffered very badly both from mitral and aortic disease. Her loss of blood from the rectum was not due to this, but to the fact that she had piles, and the discomfort from her piles was greater than the discomfort of her heart disease. I mention that to show how great the discomfort from piles may be. She died suddenly as a result of her aortic disease. Such a case reminds us that, although they chiefly belong to the province of the surgeon, piles are of great medical interest, for you will find it is no infrequent thing to come across a woman who is pale, anæmic and generally out of health, but on first inquiry and examination you cannot quite make out what is the matter with her. She is simply very unsatisfactory and never feels quite up to the mark. Many of these women wander from doctor to doctor without the doctors getting properly at the root of the matter, because they fail to ask whether these patients are constipated and to examine to see whether they have piles. There are numbers of people, especially women, going about in ill-health, solely because they are constantly losing a little blood from piles. Their delicacy prevents their mentioning this, and the doctor's oversight or delicacy prevents him from asking about it. It is remarkable how much women will allow themselves to become constipated, and yet they will not tell the doctor about it. But if you examine and find piles, and treat them, or get a surgeon to remove them, it is a striking thing to see the improvement in health which follows. To show how extreme the suffering from piles may be, I will quote you a case which I saw this summer, in which, I am glad, for the patient's sake, to say our diagnosis was wrong. In July I was asked to see a woman of about fifty years, a patient of Mr. Monier Williams, who had asked Sir Alfred Fripp to see her. She was very wasted and she passed enormous quantities of blood per rectum. I saw several of her motions, and they were almost pure blood, mixed with mucus. She was so ill that she could not get up; as I told you, she had lost a good deal of flesh, and there seemed no reasonable doubt that she had malignant disease of the bowel. Mr. Monier Williams and Sir Alfred Fripp had come to that conclusion, but as they proposed to short-circuit the bowel past the growth they asked me to see her for a confirmatory opinion. I was confirmed in my idea of malignancy because when I examined the rectum I found only trifling piles, and felt what I thought to be an enlarged gland behind the rectum, probably with a malignant deposit in it. I was present at the operation. The abdomen was opened, but the whole gut being found to be perfectly healthy, the wound was closed. As a last resort, the rectum was more fully examined, and under the anæsthetic it was easy to see that there was a general slight pilous condition of the lower part of the bowel, but not, we thought, enough to cause anything like her symptoms. However, a Whitehead's operation was done there and then for this, and when I telephoned to Mr. Monier Williams two days ago he said she had got uninterruptedly well and had gained flesh and now lost no blood from the rectum. So we must conclude her illness was due to the continual drain of blood from her piles, although they were so slight. This was an exceptional case, but let me repeat that you can often cure long lasting ill-health and anæmia in women by curing their piles. I would only say, in regard to treatment, that you can do a great deal medically for people who have a slight degree of piles by giving them simple directions, such as never to get their bowels constipated, to take some simple aperient, like confection of senna or syrup of figs, which contains senna, so that they get a loose motion. And it is a very good thing for people who suffer from a slight degree of piles to always use a sponge and cold water at the water closet rather than paper. It is also well for them to lie down for a quarter of an hour after a motion, lying on the bed. You may thus keep the condition in check and it will gradually disappear.

The next case which caused the passage of blood from the rectum, was one of duodenal ulcer, and she has just gone out. She was twenty-two years of age, and came in on account of pain in the epigastric area and collapse. No history of dyspepsia was given, but the day before she came in, about an hour after lunch, when bicycling, she was suddenly seized with an acute pain in the abdomen. This pain con-

Swan Electric Engraving Co

Tho: Guy.

From the painting by Vanderbank, the property of the Governors of the Hospital.

tinued, and the following morning the patient was found in a faint on the floor. The pain was colicky, but she was not sick. Seen immediately after admission, her pulse was 95, temperature 100°. She was in considerable abdominal pain, and intensely anæmic, her blanched appearance being very striking. Her pulse was fair, she complained of headache, she had great pain and tenderness over the epigastric area, the motions were very loose, and they containd some scybala and a quantity of altered blood. Let me remind you, in passing, that you do not look at motions nearly enough. I could tell you many mistakes that have been made because the motions have not been inspected. We could never have clinched this diagnosis if we had not looked at the motions. We did not see pure blood, we did not see typically tar-like motions; but what you often see when the blood has come from high up and has had time to alter; you see black matter with a little brown in it. You find a good deal of this brown black matter is granular. If you add a little tincture of guaiacum and ozonic ether and you get a blue colour, that proves the presence of blood. We diagnosed duodenal ulcer. The next day we found the specific gravity of the blood had fallen to 1038. Let me call to your mind that this may be sometimes of great use in aiding the diagnosis of hæmorrhage; because when a person recovers from severe internal hæmorrhage, the fluid part of the blood is added back to the blood long before the solid part; so that as long as a week after a severe hæmorrhage the specific gravity is lowered. And if you are not sure what is the cause of severe collapse, and you examine the blood, you can in this way tell whether hæmorrhage has occurred. About a year ago a man was admitted whose history was very difficult to get. He complained of great pain across his back, and he looked very ill. We could feel an obscure tumour in his abdomen, and the diagnosis lay between an aneurysm eroding the spine and causing the pain, and a growth. We thought that the lump, if it was an aneurysm, might be blood which had leaked from the aneurysm, and had tracked into the retro-peritoneal tissue; when an aneurysm bleeds behind the peritoneum it has such a difficulty in dissecting this up that the leaking is not by any means immediately fatal, and the patient often lives many days. We found the specific gravity of the blood was lowered, and therefore we concluded that there had been much hæmorrhage and therefore that the patient had an aneurysm. This was proved to be correct at the post-mortem.

All I need tell you further about the woman we were speaking of is, that she got perfectly well. The treatment adopted was, that for some time she was allowed no food by the mouth. That is very important in duodenal ulcer, because, if you allow food by the mouth, the clot which is forming over the ulcer may be dislodged, and bleeding will recur. She was given opium to keep her quiet and prevent peristaltic movement. I am not very anxious about giving saline infusions. If you think the patient is going to die from loss of fluid you may give such infusion, by the rectum or subcutaneously. But in all cases of severe hæmorrhage like this, very likely the fluid which you put in only passes out through the bleeding point.

A few weeks before she came in, I saw another case, a man, æt. 38; his history was, that he was taken ill on the night of the 24th September. He felt faint and had a headache; he was sick once, and brought up a little blood. On the next day, by the time I saw him, he was intensely pale, even paler than the woman. He had had an enema just before I saw him, and there was blackish brown stuff in the motion, such as I have described. He had a small soft pulse, of 110, a slight rise of temperature, and from the time I saw him he was never sick again. During the next fortnight he frequently passed this blackish-brown stuff; as he was very constipated, he frequently had enemata, and gradually he has got well, and now his doctor has been able to send him into the country. Notice that he was sick only once, and the woman was not sick at all. On cross-examining him, he said that for some months previous to this attack he had had indigestion and abdominal pain, and his motions had contained black stuff lately.

I looked through my notes at home of cases which have been in the Hospital, and I came across some interesting examples of duodenal ulcer. There was a man, 24 years old, who was admitted under me in John ward on January 10th, 1894. In July, 1893, he had had pain in the epigastrium and right hypochondrium. In October, 1893, he had hæmatemesis and melæna. On admission, he was very anæmic, had a hæmic murmur, and was thought to have either a gastric or a duodenal ulcer. He improved very much, but on January 22nd, he had a sudden severe pain in the epigastrium, and vomited, but the vomit contained no blood. He was pale, cold, bathed in sweat, and had a rapid, thin pulse. Evidently he had had an internal hæmorrhage. On January 23rd he vomited, but

no blood. On the 24th he vomited, but no blood. On February 9th, while straining at stool, he vomited some blood. On February 12th there happened something which clinched the diagnosis, namely, a lump appeared just below the ribs on the right side, and just outside the rectus. It was a round, soft lump. Four days later he passed a pint of bright red blood from the rectum. He often passed blood from the rectum after that, then gradually got better and went out. Now, although this man vomited a great deal, he brought up blood only once. Next, you will notice he passed bright red blood from the rectum. I have often been asked from what height blood can come, and still be bright red, when it is passed. I think if it comes from the stomach, it is never bright red when it is passed from the anus, but it may be bright red and still come from very high up in the intestine. I will quote an instance in which that was proved. It is a case of undoubted duodenal ulcer in which the blood passed was bright red. The patient was a girl, L. C., who was under me in Mary ward in 1891. She was 29 when she came in, and had hæmatemesis, abdominal pain and severe anæmia. Two days after admission she was greatly collapsed, the surface of the body was pale, cold and clammy, the pulse 130, the abdomen very tender, and on the right side of the abdomen, below the region of the gall bladder, the abdomen was fuller than before, and there was something which was dull. On the next day the dulness had disappeared. The small amount of hæmatemesis pointed to duodenal ulcer rather than to gastric ulcer, says the report. Here is the ulcer which was found; a probe is passed through it into the cavity which it had eroded for itself in the pancreas. She died from the hæmorrhage, and the blood passed from the bowel was bright red. The abdomen was opened during life, in the hope that we could arrest the hæmorrhage, but you can see now that the surgeon could not be expected to deal with it, for its floor is formed by the pancreas, and it could not have been dealt with surgically. In both these cases we have had what I do not think the books tell you much about, a soft dull lump in the region of the duodenum. That is blood clot, as is proved by the fact that it disappears, and that it feels somewhat soft. These people may bleed so furiously from the ulcer that the blood clots *in situ*, and then gradually disappears. The importance of that, as a symptom, you cannot over-estimate. Here is a large blood-cast from a duodenum, which proves that a large blood clot can form there. The case is that of William R., æt. 57, who was admitted under Mr. Bransby Cooper, October, 1842, for hæmorrhoids. He suddenly died from profuse hæmatemesis. At the autopsy, a small ulcer was found in his stomach, and this clot of blood which you see, was removed from the duodenum. This is ocular proof that large blood clots can form in the duodenum, and therefore if the other symptoms point to duodenal ulcer, the feeling of a blood clot during life is of great help in diagnosis.

Now, one or two words about duodenal ulcer. It is rare, and though among duodenal ulcers hæmorrhage is fairly common, fatal hæmorrhage is rare. Of the four cases we have alluded to only one has been fatal. The ulcer is usually in the first part of the duodenum, and the hæmorrhage is nearly always due to the laying open of the superior pancreatico-duodenal artery, as you would expect from the ulcer being in the first part. The most essential fact to remember about the condition is the latent character of the symptoms. The classical paper on the subject is the analysis of all Guy's cases for sixty-six years which was made by Sir Cooper Perry and Dr. Shaw. They found that out of one hundred and fifty-one cases of duodenal ulcer there were no clinical symptoms until either death, or perforation, or hæmorrhage occurred, in no fewer than ninety-one. Hæmorrhage, as I have mentioned, is a common symptom, but doctors often omit to look at the fæces, so that it may be found that hæmorrhage from the rectum in duodenal ulcer is much commoner than is now thought. In analysing their cases, Sir Cooper Perry and Dr. Shaw say that "in several cases hæmorrhage so severe as to cause death had not been suspected until at the autopsy the stomach and intestines were found full of blood." It is a severe blow to your reputation for the intestines to be full of blood at the autopsy and for you to have omitted to look at the motions. Sudden intestinal hæmorrhage in a person previously healthy, especially if it is severe enough to produce striking anæmia, is almost always the result of duodenal ulcer. The key to the situation in recognising such a case is to recognise that the pallor and faintness are abnormal. I saw a case of duodenal ulcer in which the doctor had been misled because he was told the patient was always pale. But going to him fresh I was struck by the peculiar white pallor which is so indicative of hæmorrhage. The motions were full of blood and duodenal ulcer was diagnosed. Remember that with a duodenal ulcer severe internal hæmorrhage often occurs,

and you judge of its amount, not only by the pallor but by the feeble, running thin pulse, low temperature, and lowered specific gravity of the blood. Then a reaction occurs and the temperature is raised. Of course, the patient's skin may be tanned or dirty, so in estimating the pallor look especially at the lips and tongue. These patients have headache and shallow, sighing, rather slow breathing, and often, as you know in cases of severe hæmorrhage, the mind wanders. Afterwards they become somewhat unconscious, but sometimes they faint right away at the beginning.

You may be inclined to ask, Can there ever be any confusion in the diagnosis of a duodenal ulcer? I will relate a case which illustrates that there can. Last March a man walked into my house very pale indeed; so pale that one could see at once there was something wrong with him. He said that in January he had a profuse loss of bright blood from the rectum, and a little pain in the stomach. He had not noticed his motions in the interval. I examined his blood for every conceivable blood disease. I wondered whether he was bleeding because he had Bright's disease, but I could not find any symptoms of that malady; the eyes were normal, and there was no albuminuria. No local rectal disease could be discovered. So, remembering the points I have just told you, I said I thought he had duodenal ulcer, and told him what to do. Six weeks later I got a telegram to say the same thing had occurred again. He had had a furious hæmorrhage in the country, bright blood being poured from the bowel, and he came up to town as soon as possible. I handed him over to his doctor in town, and saw him on several occasions, and there seemed to be no reasonable doubt about the diagnosis. About the end of July he had symptoms of dilated stomach, and vomited large quantities of food at a time. The stomach could be found, on percussion, to be dilated. We came to the opinion that he was suffering from a dilated stomach secondary to cicatrization of a duodenal ulcer. Sir Thomas Barlow saw him and confirmed that view. I urged that a gastro-jejunostomy should be done; I did not see what else could overcome his difficulty. But it was decided to wait, so we left it for a time, but the gastric symptoms got worse, therefore in September Mr. Symonds saw him and it was decided to short-circuit. On opening the abdomen there was no duodenal ulcer, but our diagnosis was not far wrong for there was an ulcer high up in the small intestine, but unfortunately it was malignant but it had cicatrized, so that it well explained the symptoms. We could not be excepted to diagnose such a condition in a man of only thirty; the chances were infinitely greater that the trouble was duodenal ulcer, but I have brought here one specimen of malignant growth of the jejunum which you can see afterwards. Our patient has been much better since the operation. This is another case absolutely proving that bleeding occurring quite high up in the small intestine will cause a loss of bright red blood from the rectum, and it illustrates a third cause of loss of blood from the rectum, namely, malignant disease of the bowel.

We now pass to another cause of loss of blood from the bowel. In the next bed to that of the woman who had heart disease and piles, there is a very interesting case of a little girl twelve years of age; she came in as long ago as May 5th, with a rash. Six years before admission she was in a hospital for six weeks with scarlet fever. Six weeks before admission here she had pains in the abdomen and knees, sickness, diarrhœa and the passage of blood from the rectum. Petechiæ appeared on the arms, hands, feet, knees, calves and legs, and the feet swelled. We found she had had, and she did have, while in the hospital on several occasions, melæna, hæmaturia, and purpura, and these have persisted more or less until the present time. Sometimes the purpura is very profuse; for instance, it was so on many parts of the body on admission. When she came in, it was thought, because of the purpura, hæmaturia and melæna, that she had Henoch's purpura. But gradually that diagnosis has been abandoned by those who have taken charge of Clinical, because the girl has got œdema, and has had definite attacks of uræmia, so there is no doubt she is suffering from chronic Bright's disease. [This was found to be so at the post-mortem which took place a few days after this lecture was delivered.] She has bled from her bowels, from her kidneys, and into her skin, because she has Bright's disease, and all people with Bright's disease are particularly liable to bleed from almost any part of the body. I am almost ashamed to tell you this again, because I am so often insisting upon it in the wards, and if you will remember it, you will save yourselves from making many mistakes. I have known a man go to a surgeon for hæmatoma in his ear, which was only there because he had Bright's disease. He was dead three months afterwards. A mistake is commonly made when the bleeding is from the urinary tract. I have seen the bladder at a post-mortem contain a crowd of bleeding

points; the patient bled from his bladder instead of from his nose. I have often told you that a celebrated doctor first knew he had Bright's disease because he had an attack of hæmoptysis. People with chronic Bright's disease may bleed into the intestine, and you may find, post-mortem, hæmorrhages under the mucous membrane. Apart from these hæmorrhages, there are at least three varieties of trouble in the intestine in Bright's disease, any of which may cause passage of blood from the rectum. Firstly, you may get acute colitis in Bright's disease. We are particularly rich in museum specimens of this colitis, and I show you some specimens. No. 809 came in in 1828. Three days before his death he had profuse diarrhœa. At the autopsy the kidneys were large white kidneys. No. 810 is a very similar case; advanced tubal inflammation of the kidneys, and you see by the black sloughs, shewing where the hæmorrhage had taken place into the submucous coat, how acute the colitis was. No. 811 was a very similar case, which was under Dr. Moxon, and died of uræmia. Sometimes membranous colitis may occur in Bright's disease, but that is more rare. Ulcerative colitis may also occur in Bright's disease, and I shew you a specimen of that. It is the colon of a woman, æt. 54, who was under Dr. Fagge, with ulcerative colitis and interstitial nephritis. The next specimen is of great interest, because it is one of Dr. Bright's own cases, and he was the first person to point out these intestinal troubles in Bright's disease. The patient from whom the specimen is taken is No. 23 in his famous "Tabular view of the Morbid Appearances in 100 cases connected with Albuminous urine." Here is the sigmoid flexure of the colon, injected, and laid open to shew the ulceration, which has destroyed a large part of its surface. The patient was admitted under Dr. Bright in 1829, with general dropsy and albuminous urine. The bowels were loose, the motions contained blood and mucus. At the post-mortem the kidneys were granular, and there was this state of colon which you see.

The next case of hæmorrhage from the rectum we had was this:—A small boy, æt. 7, was admitted into John ward on October 25th. He gave a history of having abdominal pain, sickness and diarrhœa. He also said he had vomited blood, and his mother said he had passed blood from the rectum. We examined the motion and treated it with guaiacum and ozonic ether, and I show you here the blue reaction we obtain, because he is now passing blood from the rectum, and he has done so ever since he came in. He has had several attacks of sudden acute abdominal pain all over the front of the abdomen, and after he had been in a couple of days we noticed purpuric spots, first about the knee, afterwards about the shoulder, and afterwards in various places. So I do not think there can be much doubt that it is a case of Henoch's purpura. Last year I gave a clinical lecture on the subject, and I need not refer to two very similar cases, which also had melæna, because they were published in the GAZETTE last January. So Henoch's purpura causes bleeding from the rectum, and it is a disease about which many mistakes are made. The case I related to you of Bright's disease, causing bleeding from the rectum, was at first thought to be Henoch's purpura, and lately I have seen a case of Henoch's purpura which was thought to be, on account of loss of blood from the rectum, one of intussusception, and another was believed to be appendix trouble on account of the severe abdominal pain, and in another case profuse hæmaturia led to a diagnosis of Bright's disease.

Now we come to a very remarkable case indeed, it is an instance of rectal hæmorrhage due to the presence of a foreign body. A boy came to the hospital a fortnight ago because his bowels had not been opened for several days. For a boy who had had obstruction all that time he looked very well, his pulse was good and he had not an anxious expression. I examined the rectum and it was like putting one's finger into a gravel-pit. I extracted a piece of coal, and we then gave him an anæsthetic and got away a little more coal than you see before you, that is to say several ounces. It was packed so tightly that no fæces could pass through, and it is a matter of much interest to notice that no fæces was mixed with the coal although there was much above it. It appears that he met another boy in the street who was carrying coal, and the other boy had persuaded him that this coal was liquorice, so he had taken of it as freely as you see here. Of course for a few days after it was abstracted he passed blood from the rectum, for the sharp pieces of coal had lacerated the mucous membrane.

Two or three beds further down the ward there was a man admitted the other day who said he had coughed up a lot of blood; we found he had phthisis. But he looked more anæmic than the blood coughed up would account for, therefore we at once looked at his motions, and found they contained a quantity of blood. So the man had swallowed most of the blood coughed up, and if we had not looked at the motions we should have been at a loss to

understand why he looked so much worse than the blood visible in the sputum indicated.

A man was admitted with pneumonia, on November 8th. He said that on the 7th he had a shivering fit and pain in the abdomen. On the 8th he had diarrhœa. When he came in we found he had pneumonia at the top of the lower lobe of his right lung. He had rusty sputum, but there was nothing of special interest about his pneumonia. But there again we were much struck with how ill the man looked. And, as bearing that out, his temperature was low, and in a lecture last year I pointed out that frequently a low temperature in pneumonia means that the patient is very ill. Again, his leucocytosis was slight, 15,000, showing that he had not much reaction. We asked to see the motions, and found a quantity of blood in them. Mr. Woodward's note is: "The bowels have been very loose, very dark in colour, and on examination were found to contain blood." That has been so since he has been in. If you want to get a good conception of pneumonia you must remember that the pneumococcus affects many parts of the body besides the lungs; it will cause malignant endocarditis, meningitis, ear disease, trouble in joints, acute suppurative peritonitis, and now you learn it may cause enteritis and colitis. That has long been known and taught here, and our specimens show it, though a few years ago somebody announced it as a new fact. As long ago as 1855 we knew it, because a specimen was then mounted of acute enteritis in lobar pneumonia. It is the colon of a patient, æt. 22, who was admitted under Dr. Barlow with the physical signs of consolidation of the lung, with rusty sputum. He died, and pneumonia was found, and the whole of the large intestine was found in a state of acute inflammation. The next case, a specimen of which I show you, was a man, æt. 32, who was under Dr. Pye-Smith. It shows many shallow ulcers disposed in the muscular coat. He also died of acute pneumonia.

Passing over to Miriam ward, we had a child with intussusception, which is another cause of bleeding from the bowel. This loss of blood makes intussusception liable to be confused with the frequent severe gastro-enteritis which children get. But it is surprising how rare the mistake is if proper care be taken. Of course if you can feel a tumour through the abdominal wall or in the rectum, the diagnosis of intussusception is easy. In intussusception you get first bloody diarrhœa, and later, constipation; but I think in any severe case of intussusception, usually at some period of the illness nearly pure blood is passed. But if the disease is gastro-enteritis the motion is rarely pure blood; the fæces are mucus, blood, and fæcal matter mixed together. And if the child has gastro-enteritis the constipation does not come on until he is convalescent. In intussusception, as the constipation comes on, the patient gets worse. In gastro-enteritis there is pyrexia and often severe vomiting, but neither is common in intussusception.

The last case which we have recently had in the wards shewing hæmorrhage from the anus was one of typhoid fever, and that is such a common cause that I need not say very much about it. It comes on usually at about the third week. If it occurs only once it is not very unfavourable. If slight and the blood has remained some time in the intestines, it is tar-like. In slight cases of hæmorrhage in typhoid, the prognosis is not made worse by it, but in severe cases, when bright blood pours from the rectum, the outlook is very grave. The chief interest lies in the treatment. If the patient is losing a large amount of blood from the rectum you must not give cold baths. The next point is, milk frequently curdles in typhoid fever, and if much blood is being lost from the rectum, peptonise the milk, so as to avoid the risk, that curds may mechanically damage ulcers. Inject morphia and keep the patient under it, or give starch and opium enemata. I do nothing else, as a rule. I do not think there is any proof that ice to the abdomen mends matters; it is often uncomfortable. Some doctors give oil of turpentine, 10 ♏ every hour or two, but I think you will find opium more serviceable as a sheet-anchor.

Other causes of the passage of blood from the rectum which I have jotted down but which I will only mention as we have no illustrative cases in the wards are, in the first place, that people who are very constipated are very liable to pass a little blood by the rectum. Do not be alarmed at that; it only means that the hard fæces have irritated the rectum. If such persons are hypochondriacs they will bring you bottles of fæces streaked with blood and become quite melancholy about it.

At the last lecture I gave an instance of bleeding from the rectum as a result of malingering, the woman scratching the rectum with a pin and so passing blood.

There was an interesting case under me not long ago in which tubercle caused blood from the rectum. Considering the frequency of tubercular ulcers of the intestine, it is strange

that the passing of blood from the rectum is not more common. This patient was æt. 17, and came into Miriam ward very emaciated and anæmic, giving a six weeks history of vomiting. She said the vomit contained blood and the fæces were black. She had a hæmic murmur and there were no physical signs except a few râles at the apex. We thought she had a gastric ulcer. She died suddenly ten days after admission. The stomach was healthy, but she had a tubercular ulceration of the cæcum and vermiform appendix, and old phthisis of both apices. It was clear that the blood came from the tubercular ulceration.

A few years ago I gave a lecture on purpura hæmorrhagica, pointing out that the subjects of it might bleed from the rectum. And sometime ago we had a case of malignant disease of the pancreas, in which a growth had eroded the duodenum, and so blood had been passed from the rectum. Any severe gastro-enteritis may cause it. I saw a patient not long ago who had a very severe gastro-enteritis with hæmorrhage from the rectum; and there is a man at present in the hospital suffering severely from oxalic acid poisoning, and he has got severe enteritis, so probably blood will be passed by the rectum in that case. Only a year ago I mentioned in a lecture a man who had embolism or thrombosis of his abdominal aorta. I cannot go into the symptoms now, but remember that embolism or thrombosis of the aorta or of the mesenteric vessels will often cause profuse loss of blood from the rectum, because it leads to gangrene of the gut. Any form of colitis or dysentery will cause it, and it may be the result of a polypus, sometimes of ankylostomiasis, which we are so much interested in here, because of the work which has been done at the Gordon Laboratory. Sometimes blood from a gastric ulcer will come down all the way and be passed per rectum.

I have heard people express surprise at the fact that an abdominal aneurysm rarely, if ever, ruptures into the bowel. It is not surprising, because the bowel is so movable that an aneurysm easily pushes it aside, so that bleeding from the bowel as a result of aneurysm is excessively rare.

Papers by Guy's Men.

Further Note on the Red Light Treatment of Small-pox. By T. F. Rickets, M.D. Lond., M.R.C.P., and J. B. Byles, M.B., B.C. Cantab., F.R.C.S. Eng.—*Lancet*, November 26th.

Nurses' and Students' Choral Concert.

The first Concert of the season was held in the Board-room on Tuesday last, December 13th, before a large and appreciative audience. The concert opened with a "Canon," "Non Nobis Domine," by Byrd, a lugubrious composition, which to our mind, acted like a wet blanket on the audience, but gave the basses an opportunity, of which they availed themselves. Had this "Canon" been sung from the stalls of a Cathedral Choir it would have been much more in place. This was followed by a part song of Pinsuti's, "In this hour of Softened Splendour," well sung by the full choir, but in our opinion, taken too quickly, which spoilt its beauty, and the effect it should have made on the audience. The next item was a quartette by Martin, "Haste ye soft Gales," sung by Messrs. Hammond-Smith, W. Reeve, R. Felton, and Alan Forty, but the ensemble left something to be desired. After a three-part song, "Heaven," by the Nurses' Choral Society, Nurse Dickenson favoured us with "Hasten to Me," by Mascheroni, displaying a sweet soprano voice of good compass; she was heartily applauded. This was followed by a madrigal by Sullivan, "Joy and Sorrow," very nicely rendered by Sisters Lydia and Lazarus, Mr. W. Reeve and Mr. R. Felton; but the one thing lacking, to our mind, and in fact to nearly all the concerted choral music, was the enunciation of the words, it was difficult to know what it was all about; the principal thing aimed at seemed to be to get the right note, the words were left to take care of themselves; this ought to be remedied without delay. Nurse Woodward next gave us a violin solo, "Berceuse," by Jocelyn; this was very enjoyable, execution, intonation, and expression being admirable. A trio, "Wine the Magician," by Balfe, followed, and was well rendered by Messrs. C. W. Greene, F. A. Barker, and G. C. F. Robinson. This was followed by a part song, "Tell me Flora," by Pinsuti, in which the basses again distinguished themselves. Mr. A. Alcock next obliged with two little ditties by Lohr, "Love's Episode," and "If all the Young Maidens," displaying an agreeable voice, and bringing out all the points in both words and music very successfully; he was heartily applauded, and the audience would gladly have heard him again. He was followed by the Students' Glee Club in the quartette, "Banish, O Maiden," by Lorenz. This was followed by a part song "Sweet and Low," by Barnby, sung by the full Choir; this was carefully sung but we could hear no words, and we were unaware that it was dance music; if the composer had intended it to be sung as a waltz, he would doubtles have mentioned it. Sister Lazarus came next with two ballads, "The Rosary," by E. Nevin, and "When the Birds go North again," by Willeby, both most artistically sung, and well applauded. The first part finished with a descriptive chorus by Gaul, "Lord Ullin's Daughter," sung by the Nurses' Choral Society (contraltos) and the Students' Glee Club, Mr. H. D. Wyatt taking the tenor solo; this went very steadily, and was well received.

Part two, commenced with a piano solo by Mr. Alan Forty, "Canzonetta del Salvator Rosa," by Liszt, and "Mélodie," by Stojowski, both well played and applauded, but to our mind more of the singing quality infused into the performance would have improved both pieces. The Choir then sang a part song by Elgar, "My Love dwelt in a Northern Land," which was followed by a Sextet by Sullivan, from the Opera of "Patience," "I Hear the Soft Note," sung by Sisters Lydia, Patience, and Lazarus, Messrs. Reeve, Felton, and Alan Forty, and which was much applauded, but we did not hear the words. Mr. Felton next followed with Handel's "Droop not Young Lover," very nicely sung and much appreciated. After a quartette by the Glee Club, "Lovely Night," by Chwatal, Nurse Woodward again delighted her audience with a violin solo, "Kuywiak," overcoming its many difficulties with the ease of a professional. The audience would gladly have heard it again, but had to be content with a bow and smile. The full Choir then sang the part song "Lilian," by Waddington. This was steadily sung, and then Nurse St. John followed with two songs, "Le Soir," by Ambroise Thomas, and "I Wonder," by Palliser. These compositions, to be effective, demand flexibility of voice and tasteful expression, and the rendering of the two songs left nothing to be desired. After the pretty duet "Echoes," by Noir, which was well rendered by Nurses Crocker and Tippets, followed the humorous quartette "Cigarettes." In this the male quartette most nearly approached their form of last season, and the audience fully appreciated the humour of the little sketch, "Drake's Drum," by the full Choir, which ended the programme.

It only remains to add that the best thanks of everybody is due to the conductor, Mr. Henry Taylor, who was ever watchful, and kept his forces well in hand; and to the accompanist, Nurse Margaret Taylor, who by her intelligent playing and alertness assisted greatly to the success of the concert. We don't think that the Quartette party or the Choir were up to the high standard they reached last year, and we hope to hear a marked improvement at the concert after Christmas.

To Intending Buyers.

I was sitting in a corner of the railway carriage comfortably reading a motor journal when the man opposite gently tapped my knee. He was a thin, pale man, with a wild eye and dirty hands.

"Excuse me," he said, "but are you thinking of buying a motor?"

"Well, for some time past," I replied, "I have ——."

"Quite so," he said, "you are the man I have been waiting for; you will be glad you met me. Sir, I like your looks, and that stethoscope protruding from your braces tells me you are of my own profession. Now tell me, can you afford to pay £750 for a car and £4 a week to an expert to look after it? No, I didn't think you could. On the other hand, have you the tastes and inclinations of a jobbing tinker? Again no, of course not; you rightly regard the suggestion as an insult. Well, then, listen to me.

"A year ago I bought a small car which I was assured was of the best make. The car arrived in charge of a man from the works who stayed a week and taught me to drive. Sir, I assure you, that week was the happiest of my life: that machine ran —— oh, how it ran! I did my work in half the time (I practice in the country you will understand), and my rivals were livid with envy as my triumphing passage drove their wretched dog-carts into the wayside hedge.

"In due course the expert left and I had to grapple with the infernal contraption alone and unfriended. The very first occasion I seized the starting handle—— By the way," he broke off, "have you ever started a motor car?"

"No," I replied, "but I understand——."

"All right, say no more; *I have*. You press a button and the car does the rest. What really happens is this. You grab a handle and pull sharply; as a result the engine gives a sullen grunt or two. Then you find that you have forgotten to switch the current on. Well, you put that right, and try again: more grunts from the engine and a pain in your wrist. Then you play about with a lever or so and joggle a thing called the carburettor and take another lug. By this time the beast is thoroughly roused and the handle flies back and hits you —— hard, and you dance round the yard nursing your wrist, what time the kitchen windows are shut abruptly by an outraged domestic staff.

"But this by the way ——. Where was I? It doesn't really matter where I was: generally five miles from home in the rain. If the trembler trembled the sparking plug wouldn't spark, or if the plug sparked the carburetter wouldn't carburet. If the various loathsome components did work more or less, I punctured a tyre. I will not weary you with technical details; that unspeakable contrivance was as much trouble as twins and just about as useful. My sole pleasure was afforded by my worthy gardener—groom—boots—chaffeur, who would persist in calling the throttle the snaffle.

"You think I am easily amused and you are right. But the fact that I came to look for and welcome that harmless idiocy as the one bright spot in the all-pervading gloom will give you some idea of the deplorable state of my higher mental processes induced by motor ownership.

"My prolonged absences from home have awakened first the alarm, then the suspicion of my wife. I explained that there was enormous pressure of work: unfortunately an inspection of my visiting list showed her at once that I lied, and I despair of ever resuming that happy life of mutual confidence that was once my chiefest joy.

"My innocent babes look on me as their merry playmate no longer but rather as a morose tyrant whom it is usually unsafe to approach, and they are right; my naturally sweet disposition is permanently soured.

"My cook left yesterday. She is seriously inclined and said, quite properly, that my language was a disgrace to any so-called Christian household.

"And now I am on my way to spend a really jolly Christmas, with no cook, an estranged wife and family, a depleted bank balance and a rapidly depreciating mass of iniquitous complexity cumbering my coachhouse. Of course, if you ask any motorist he will tell you that he has no trouble at all, that life is all sunshine and roses. But he lies, they all do, they can't help it. I am prepared to maintain that one week's possession of any mechanically-propelled vehicle will transform an ordinarily honourable man into an habitual trifler with the truth. This question of the degrading influence of motors on morals should receive the serious attention of all earnest social students.

"If you tax these unfortunates with their unblushing perversion of plain facts, they will say that they like playing about with the thing, that it is part of the game, and so on. Of course, they are still lying; no sane man really enjoys lying in the mud, reaching with a screw-wrench for a nut he can't see and couldn't move if he did, while hot oil trickles into his right eye. I could say much more, but I can see we are approaching my station."

"But surely," I protested, "you exaggerate grossly; now in this very paper I see a letter from a man who says that he has never had any trouble, that the expense is trifling, while——."

"I know all about that," he replied. "In fact I wrote it. If you read on you will find some more of the same sort. I wrote them too. You don't expect one to have the laugh all one way all the time, do you? I think not. Good morning." W. R. C.

Change of Address.

Mr. Percival S. Campkin, L.D.S., from 30, Wilton Place, S.W., to 40, Curzon Street, Mayfair, W. (Telephone, 4602 Gerrard).

Dr. John Fawcett, from 24, St. Thomas's Street, S.E., to 66, Wimpole Street, W. (Telephone, 3313 Paddington.)

Mr. Edmund S. Hall, M.B., from Itchen, Southampton, to Bath Lodge, Bitterne, Hants. (Telephone, 75x Southampton.)

Mr. A. Hammond-Smith, L.D.S., from Guy's Hospital to Anerley, 211, King's Road, Reading, Berks.

Dr. Charles E. Hicks, from 3, Handford Road, to 157a, High Street, Huntingdon.

Mr. Percy A. Peall, M.B., from Guy's Hospital to 1, Aberdour Gardens, Goodmayes, Essex.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Pupils' Physical Society.

The fifth meeting of the session was held in the College, on December 3rd, 1904, under the presidency of Mr. A. R. Brailey. The evening was devoted to the study of clinical cases, the following being shown:—

Exostosis of the humerus ... ... Mr. Bankart.

Syphilitic (or lupoid?) multiple ulcers of the skin, with chronic enlargement of joints ... Mr. J. M. Watson.

Spasmodic torticollis ... Mr. A. S. Morton Palmer.

Aneurysmal varix of the orbit ... ... Mr. Sheaf.

Gumma of the eyelid ... ... Mr. Bankart.

There was a considerable discussion of each case in which the following members took part:—Messrs. Peall, Webber, Bell Walker, Myott, N. I. Spriggs, Goss, Cameron, Maybury, Stevenson, Leipoldt, F. W. Morton Palmer, E. Bellingham Smith, the President and the Secretary.

Thirty-five members were present. The society adjourned for coffee shortly after ten o'clock.

Pass List.

University of Oxford, December, 1904.

FIRST EXAMINATION FOR THE DEGREE OF M.B.

O. G. F. Luhn.

University of Cambridge, December, 1904.

THIRD EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES.

Part I.—F. D. Crew, C. F. Fothergill, C. W. Greene.

Royal College of Surgeons of England, November, 1904.

FINAL FELLOWSHIP EXAMINATION.

H. Davies-Colley, A. R. Brailey, Kenneth Black, N. Ivens Spriggs, F. H. Parker.

Appointments.

Civil.

Black, Kenneth, F.R.C.S. Eng., has been appointed Casualty Officer to St. Thomas's Hospital.

Coplans, Myer, M.D. Lond., D.P.H. Camb., is appointed Medical Officer of Health for the Wheatenhurst Union of Wiltshire.

On some rare forms of Jest occurring in Lecture Rooms.

"Full well they laughed with counterfeited glee
At all his jokes, for many a joke had he."

On the face of it, a misleading title! Can a real live jest first see the light under circumstances so uncongenial as those of an ordinary lecture room, with its front rows all attention to the serious matters in hand, but rising, tier upon tier, through apathy and somnolence, to profound repose; a real live jest I say, with root enough to live in our memories, and vigour enough to grow to the full maturity of anecdote. It hardly seems possible. I know that in the lecture room, as in the law courts and in the police courts (and in saying so, I mean no disrespect either to Mr. Justice Darling or to Mr. Plowden), there is engendered a monstrous kind of spurious jest, which indeed is hailed with a great show of approbation at the making, but which, when once born, shows no further sign of life, a consequence, perhaps, of the grave difficulties attending its delivery.

Yet I have attended so many lectures and have been so earnest in my efforts, that I am become the possessor of several more or less perfect examples of these sporadic jests. Of one thing I am becoming increasingly certain, my collection grew most rapidly in the early days of its existence, and that, although the lectures which I was then attending, were delivered North of the Tweed, a country which, according to a widespread belief, is fatal to delicate and subtle jests, and where only the hardiest stand any chance of livelihood.

That my collection contains so many of these North British forms, is due, I think, mainly to the fact that in the Scotch lecture rooms, there is still practiced the excellent plan of question and answer, and secondly, and in a less degree, to the pleasant laxity of discipline characteristic of Scotch universities in all their doings. If the harrassed lecturer is to keep order among a crowd so unruly, he must rely mainly upon his mother wit. I remember a signal success of a young mathematical lecturer. He had asked one of his audience to demonstrate some problem on the black-board; the man could make no progress, he stumbled and finally stuck outright, the lecturer regarding him sorrowfully the while, clicking his tongue at him, tchk, tchk, tchk, and shaking his head. Finding that the laugh was against him, the student protested that he thought it hardly fair to expose a man to ridicule for mathematical incompetence. "It was a special gift" he said, hinting at rare talents elsewhere, "Sit down, sir," said the lecturer, "Sit down, I have too high an opinion of you not to think that you have done just your very best."

As a rule, this same lecturer was less happy. At one time, certain unruly spirits on the back benches having made unto themselves a paper dart, exceeding sharp, launched it at him and succeeded in hitting him pretty hard on the top of his head, where, young as he was, the bald was already beginning to show. The lecturer was gravely upset; he called for confession from the culprit; no confession was forthcoming, so the infatuated man proceeded on a weary round of the entire room, asking each in turn two questions; had he done it, did he know who had done it? The men were delighted at this unlooked for respite from labour. He had got about halfway round, when a tall figure in the central tier of benches rose up. Here then, all thought, was the culprit about to confess. The lecturer stopped and waited for him to speak. The man was wearing a long overcoat. Amid breathless silence, he slowly unbuttoned it, took it off, folded it, and —— sat down again. The lecturer did not complete his round of questions.

After that, I am told that for long this unhappy man—so easy is it to make or mar a reputation—was the constant mark for practice with paper darts, but that in the end he regained the upper hand. Having received one day a stinging flick full in the face, he was explaining—as indeed he had often done before—that such conduct was not gentlemanly, that it was not even Christian, when a second dart hit him hard on the cheek; "Besides," he added, "its damned sore." I believe that for months thereafter he was listened to with attention.

As an example of a student's success, let me tell the following. The professor of Latin—Humanity we call it in Scotland—was explaining to our degenerate selves, how hardy were the Roman Youth of our own age; "Often," he said, "they would swim three times across the Tiber before breakfast." At this point he observed a man talking to his neighbour and that neighbour convulsed with laughter,—two things to which the worthy professor particularly objected. "Come," he said, "Come, Mr. Macallum, if you have anything more worthy of our attention than what I am saying, pray say it aloud." Mr. Macallum kept silence. "Come," said the misguided professor, "let us all share in it; it seems to have proved amusing." Whereupon Mr. Macallum lost his temper. "Well, professor, I was just saying, to my friend Mr. McLachlan here, that if the Roman youth was to swim three times across the Tiber, they would be on the wrong side for their clothes."

My last specimen of lecture room humour I have long regarded as the best of my collection. The professor of Greek lectured in a room immediately below the professor of Logic and at the same hour. To him it was a constant source of annoyance that his colleague ended his lectures with great regularity, five minutes before the clock struck the hour, and the shuffling of feet above, as the men poured out, was wont to disturb his perorations. One day, things came to such a pass, that a piece of plaster above his head was dislodged, and fluttered to his feet. "Gentlemen," he said, "I am afraid that my *premises* will hardly support the *conclusions* of the Professor of Logic."

To this I have only to add, at the risk of appearing over bold, that I am now in a country where (its inhabitants are wont to insist) jests grow in astonishing profusion, and with a development unknown in our northern cail-yards, that I am still an enthusiastic collector, and that I am still attending lectures.

The Treatment of Cardiac Disorder.

A paper read before the Physical Society on November 19th, 1904, by Mr. Harold Mann, M.B.

(Continued).

The consideration of angina, naturally leads us on to discuss :—

Aortic Disease.

Of the causes of aortic trouble, you will remember, endocarditis, atheroma and mechanical strain. I propose to enumerate those symptoms which may arise, and which may call for treatment in a case of aortic regurgitation.

(*a*) Vertigo and vomiting, I shall take first, because at times they are the first evidences of the trouble, in a patient who gives no history of heart trouble. If this be the case, rest is imperative, for the vomiting, which is reflex, is a sign that the left ventricle has reached the limits of its endurance, and the heart is failing. It is especially at this stage, in uncomplicated cases of aortic disease, that the use of digitalis is indicated. Pages have been written for and against its administration. The following points may be of service :—

1. Do not add the tincture of digitalis to any tonic the man may be taking, but give him a dose of ten or fifteen minims in water early in the morning: repeat the dose every other morning, noting the effect on the pulse and on the quantity of urine passed.

2. If after staying in bed for two days without digitalis there still remains irregularity of the pulse, the heart will be benefited by its temporary administration.

3. It is contraindicated if either headache or sickness are present, or with a pulse-rate under 75.

(*b*) Insomnia. — Aortic cases are frequently bad sleepers, and you may find it difficult, even with hypnotics, to ensure the amount of sleep necessary for their recovery; besides this, it is the aortic patient in particular who is liable to delirium. Frequently, a patient who has been quite tractable during the day, becomes with the approach of night, wildly maniacal, and he will spare neither strength nor cunning to escape from his imaginary persecutors. In such a condition they need constant attention, for when after an hour or more of almost incessant struggle and excitement, it would seem that the tired heart has at last rebelled against the strain, they will suddenly leap from the bed, fling a chair across the ward, and make a bolt for the window. There is but one drug of any use, morphia, and occasionally even that may fail. For simply insomnia, the books mention chloralamide and even ammonium bromide; they are quite useless. Morphia is not only efficient, but absolutely safe; you must give at least ¼ grain, if you give less you will simply get the stimulatory effect of the drug.

Case 6.—C. G., male, æt. 51. Admitted into Stephen on May 21st, 1904. Had syphilis 30 years ago; for the past year has complained of breathlessness. Signs of aortic regurgitation and stenosis: became delirious on May 23rd; relieved by morphia. On May 26th, much worse; continually attempting to leap out of bed. Morphia, gr. ½, would quiet him only for an hour of two. On May 27th, he was much the same, with practically no sleep; morphia useless. On May 28th, morphia was quite useless. Hyoscine, gr. $\frac{1}{150}$, quieted him rapidly and gave him seven hours sleep. The pulse and general condition improved; he became quieter. About nine days afterwards he died quite quietly. The hyoscine was repeated on one other occasion, and again was successful. Although he was obviously a hopeless case, I think you will agree that neither time nor treatment were wasted in obtaining such an end. In two other patients I have found hyoscine of much service.

(*c*) Headache is very common and persistent; it certainly yields most readily to the nitrites. Sodium nitrite is a convenient way of administration; a grain of the salt combined with caffeine citrate, grs. 7 and half a drachm of magnesium sulphate, suitably flavoured with an aromatic tincture, makes a good mixture.

(*d*) Temperament.—Quite a characteristic feature of these people is their temperament. Reckless in their habits, with anger easily aroused by trifles, they frequently form trying patients, and a painstaking nurse is invaluable.

Of the anginal attacks and sudden death we have spoken above. With regard to prognosis. Given a patient of not more than 35 years, an easy berth, such as a lift attendant or door-keeper, and a moderate degree of incompetence, ten years is about the usual duration of life; very occasionally it may be fifteen. They should always be warned of the dangers of over-feeding. Two cases, I can remember, who were in Stephen under Dr. Pitt about three years ago with only a moderate amount of aortic trouble, died suddenly after eating large dinners, for they were huge eaters. In both cases at the autopsy, the stomach was found distended and full of food. A caution is also necessary as regards straining with constipation.

According to Clifford Allbutt, if the lesion be syphilitic, ten years may be added to the usual duration of life. I have recently had a man in Stephen with a diffuse periostitis of the right humerus, apparently specific in origin, who was also suffering from aortic disease. Under the influence of mercury and iodide, the trouble in the arm improved, and the bruits became altered in character. Dr. Pye-Smith describes the case of a man of 32, who died from aortic disease, and where an ulcerative aortitis without atheroma was found post-mortem. Signs of syphilis were found. Rheumatism and chorea were out of the question. One is inclined to wonder whether the above case is of the same nature. He was admitted on July 25th, and discharged on September 6th, much better and with no cardiac symptoms. I have seen him this week, and he continues to do well; he is a

crane-driver and the work is fairly heavy. He is still taking potassium iodide. (Case No. 15.—G. L., æt. 38).

Mitral Disease

I propose to deal with under three headings.

(*a*) Patient is found to have a bruit; remembers that at times he gets "out of breath" rather quickly. There are no signs of backward pressure, and he has not come up to be treated for heart trouble.

(*b*) There is found an enlarged heart, with signs of old disease. At the time of examination, it is failing, it may be for the first time.

(*c*) "Wrecks."

(*a*) The presence of a mitral-bruit. No signs of failure.—The first point to consider is the age of the patient. Rheumatic endocarditis in children, as you know, is more commonly followed by pericarditis and myocarditis than in the adult, so that for this reason, a rheumatic attack in childhood is of greater gravity. If you glance at my list of cases, you will notice that in the children, the symptoms date from the first attack of rheumatism, but among the adults, there was almost always an interval of years before the auricular systole betrayed the presence of a stenosed orifice with its characteristic bruit. Particularly at the age of puberty should you be careful that neither by prolonged strain uor general exuberance of spirits, such a heart is not unduly excited at a time when it is undergoing a natural enlargement as a result of general development. If there were any bruit present before, the age of puberty is a season for watchfulness. Among adults, your advice will be sought as to how much they may do, and what they should not do. The answer must be supplied by the applicant himself. There *is* no reason why these patients with a slight degree of mitral regurgitation should not enjoy life with their fellows, if they do but remember to find out what they *cannot* do without discomfort or exhaustion, and never do it. The pleasure of cycling does not depend upon the rushing of each and every hill, still, among your most disappointing patients in this class of disorder will be not those who do too much, but those, who in a foolish and melancholy despair, sit down, to eke out the miserable existence of the unfortunates who never do anything at all. Should you at any time find that among the more energetic there is some slight indication of cardiac disturbance, a temporary rest and then a course of the Nauheim treatment, or some modification of it, will prove of much service. They are a class of patient who derive much benefit from the application of the combined baths and exercises, from which they may return to live thirty years of a useful and energetic life.

(*b*) Enlarged heart. Old disease. Failing.—You will see many examples of this in the medical wards, and it would perhaps be best if we follow up the patient from the time of his admission, describing the complications as they arise, and how they call for treatment. On admission, the examination to be as brief as possible, auscultation being directed towards finding out the valves diseased, and not to making a diagnosis. The next point is to determine the extent of air entry into each lung. Is there fluid at the bases? and if so, how much. Rest is, as you know, of more importance than immediate drug treatment, and the first few hours, especially, as indicating whether your patient is recovering from the shock of his journey to hospital. For this reason, count the heart-beats, not the pulse, every half-hour, noting as well, tension or irregularity at the radial. The question as to whether your patient is suffering from acute failure, or no, will decide you as to treatment at the end of the first few hours. If you obtain a history of increasing œdema and dyspnœa, in spite of rest, delay is out of the question, and a venesection is indicated.

Case 17.—W. D., male, æt. 38. A stevedore, admitted on August 14th, 1904. Mitral stenosis was diagnosed in 1894, which was the first time of failure. This is the second occasion, and was due to an acute bronchitis. On admission, his condition was critical, a venesection of ʒ. xxii, with strychnine, pulled him round, and subsequently he did well. The cough was very troublesome for some time afterwards, morphia was successful in procuring him sleep, and contributed in no small way to his rapid recovery. He was discharged, at his own request, on September 21st, and at the present time (November 16th), he is back at work and feels very fit.

One or two points about venesection in heart disease:—

(1) Have your patient sitting, propped up in bed, with pillows; by this means you will have an earlier indication of the effect of removal of any particular amount of blood, faintness, etc.

(2) Use the median basilic. Dissect a small length of vein out, quite free from the surrounding tissue: have a bandage tied round above; open the vein with the knife transversely, holding the vessel below, with forceps.

(3) Watch the effect of the bleeding. There is nothing so marked in medicine as the relief which a well timed venesection will give to cardiac cases. Sometimes a patient who has had no rest for days, will be sleeping like a child before the venesection is over, with a good steady pulse, where before there was irregularity and dyspnœa.

(4) The amount of blood withdrawn will vary according to the severity of the case. Usually you will do well with fourteen to seventeen ounces in an adult with bad right-sided failure.

(5) Just as the venesection is finished, give a hypodermic of strychnine, 5 to 10 ♏.

(6) A gauze dressing applied firmly; no stitches or ligatures.

The first symptom calling for treatment is—

Sleeplessness.—It is not sufficient to hear whether a patient has slept or no; you must ask *how* they sleep; if they sleep for four hours and wake up with a nightmare, the rest is of *no use to them at all.* The rest for cardiac cases must be deep and prolonged for it to be of

service. For this reason; if you find they are only disturbed *once*, give a hypnotic. In ordinary cases, chloralamide is very successful and quite safe, thirty grains may be given; it dissolves in brandy or acid solutions (hydrobromic may be used). Much the best way is to dissolve it in a cup of hot bovril or beef-tea, to be taken just before the patient is settled for the night. In some of the books you will see it stated that chloralamide decomposes in hot water. I am indebted to Mr. Finnemore, F.I.C., for kindly investigating the point. He found that the substance is practically unaltered after exposure to a temperature of 212° F.

Chloralamide.
Boiling water poured on—
Two portions taken,—
(*a*) Allowed to cool, and crystallized out.
Melting point taken, 115° F.
(*b*) Evaporated on a water bath.
Melting point of residue, 106·5° F.

Chloral, melting point, 94° F. Chloralamide, melting point, 115° F.

The advantage of this method of administration is obvious, the patient is unaware of the use of the drug. Hypnol is useless; paraldehyde is nasty, and may make them sick, a possibility not to be thought of in such cases. If chloralamide fails, nepenthe, twenty to twenty-five minims (not tincture of opium), or a hypodermic of morphia, gr. $\frac{1}{6}$ to gr. $\frac{1}{4}$, will often enable the patient to turn the corner towards recovery. Often you will find an injection of ten minims of strychnine, by steadying the pulse, will enable the patient to drop off to sleep, even without morphia subsequently.

Prolonged vomiting.—It is as well to remember that there are three causes for sickness in failing heart trouble:—

(*a*) Sickness resulting from the use of digitalis, either owing to the toxic effect of prolonged administration, or to simple intolerance, as is sometimes the case. You may sometimes find that individuals unable to take the drug in combination with strychnine, will take it in small quantities of water. At times even this impossible.

(*b*) Sickness in advanced stages of right sided failure, where the gastric veins are engorged with blood, may be checked by the substitution of rectal feeding for oral feeding, thus allowing the heart time to recover, instead of the trouble being intensified by the incessant vomiting.

(*c*) Reflex vomiting.—This is most certainly of central origin, due to vagal irritation. Neither the omission of digitalis from the drug-list nor the employment of rectal feeding is of any use in the treatment of this condition, which, when it occurs in the last stages of heart disease, is one of the most distressing sights in medicine. On the post-mortem table you will see an *empty* intensely congested stomach, with possibly one or two submucous hæmorrhagic areas.

Case 5.—Fred W., male, æt. 23 years. This man, a horse artillery driver, was in Stephen, No. 3, April 27th, with a soldier's heart, weighing 40 ozs.; he was vomiting for nearly four whole days before he died. Subcutaneous injections of morphia will make them more comfortable, but will not stop the trouble. Bismuth salts, cerium oxalate and atropin are useless; cocaine is mentioned; I have not tried it. There is, however, one drug which is of service, hydrocyanic acid (dilute). When given in five-minim doses every three hours in two teaspoonfuls of water it stopped the vomiting in the case of this patient, and subsequently I have always found it diminish the trouble to such an extent as to give the sufferer, that which we all desire, a comfortable end.

Temperament.—Just as in aortic trouble we made reference to excitability and passion, so in mitral disease one recognises the tendency to melancholia. The aortic will give vent to his anger if the food is not to his liking, the mitral will leave it untouched, in the exceeding greatness of his misery, and even when they are not in this condition, there is a nervousness for their relatives and their banking account, so that they will leave the ward for their homes, in order, as they think, to set matters right. Possibly it is on this account that they are often such difficult patients to treat. (Case H. B., July 18th.) When *once* the œdema has disappeared, the cough has ceased its hacking character, and the incessant headache has given place to a wholesome desire for food, they would be flitting, and you will find that a sympathetic reference to the family which has lost its breadwinner, or a kindly enquiry for the little business which has sadly gone to ruin, will gain for you the confidence of your patient (without which you may ply your drugs in vain), and is in *no* way crossing that hard and fast boundary which must always be set between the province of the chaplain and the medical man.

Bronchitis.—Of course this will only improve as the heart itself recovers. Venesection relieves it promptly. For the irritating cough which may remain during convalescence, codeine is very successful. Half a drachm of the compound tincture of camphor (B. P.), with a drachm and a half of the Guy's "Linctus Codeinæ," which contains virginian prune, is a palatable and efficient method of administration.

About four days after the admission of such a case as we have been considering, the heart-sounds will be worth auscultation, and from this time the observance of them from day to day, both during rest and after exercise, is a matter of importance, both as regards treatment and prognosis. This is no place to discuss the diagnosis of mitral obstruction: remember, however, that:—

1. The great majority of cases of mitral obstruction in young people, die about the ages of 33 to 35.

2. That the presence of a regurgitant bruit with a presystolic slap, is at least evidence that the left auricle is performing its function. For the presystolic bruit, you will recollect, is really systolic in time, and represents the work of the auricular systole.

3. That the substitution for this presystolic, of an early diastolic bruit, indicates that the auricle is played

out, and that the hypertrophied ventricle is performing the double function of sucking and pumping.

4. That the disappearance of this early diastolic bruit is a sign of still more gravity, for now the ventricle as well as the auricle is failing, and you must be ready with your venesection and hydragogue cathartics if you would prevent the general water-logging that is to follow. In a similar way, the disappearance of the accentuated pulmonary second sound may indicate either that the ventricular output of the left side is gaining on regurgitation or that the *right* ventricle is dilating under the strain of right-sided congestion.

Purges.—By far the best purge in failing heart disease is jalap, given in the form of the compound powder. The ordinary hospital patient requires a dose of from one to two drachms. The result is a watery evacuation, which if repeated will assist largely in reducing œdema. Do not forget that jalap should be ordered "cras mane," that is to say, about five o'clock in the morning. Failing this the administration of croton oil is indicated.

Cardiac tonics.—Of these digitalis stands alone of first importance; combined with strychnine it forms the sheet anchor of drug treatment. If sickness occur you may give it hypodermically in the form of Borroughs and Welcome's tabloids (digitalin) dissolved in distilled water. Do not inject the official tincture subcutaneously, it is likely to cause local inflammation. Still another method of administration is to give the infusion of digitalis per rectum. Digitoxin by the mouth is likely to increase any sickness. *Strophanthus* is mentioned to you as of service, because it is not likely to cause sickness. In my opinion it is in no way likely to influence the pulse either. That is to say, in any patient with cardiac vomiting.

Convallaria majalis and cactus grandifloris I have found good gastric bitters. The latter is mentioned as serviceable in the palpitation of Graves' disease. I have had no experience of it.

Barium chloride gr. ½ to 2 (said to act like digitalis) in my hands has proved an excellent laxative. During convalescence arsenic and iron will be of much service.

Dietetic treatment.—In some ways this branch of the subject of my paper is the most important of all, because it is most neglected. If you will reflect for one moment as to the importance of careful dieting in those disorders of the heart which we termed functional, and remember that an unwise meal, or an injudicious supper are liable to "trip up" even a perfectly *healthy* heart with the onset of palpitation or an anginal attack, you can realise the importance of choosing your patient's diet in organic heart trouble. You may, in your turn, be called to see a patient suffering from secondary cardiac angina, and be told, as I was, "Oh! he eats what he likes." Remember, that such is the *worst possible treatment* for any form of heart trouble whatever. The diet must be carefully chosen, and chosen for each individual case. Even when this is the case, vomiting is at any time likely to prematurely close what might have been a useful life. Four out of the thirteen fatal cardiac cases I have had upstairs, died immediately after one or more attacks of vomiting.

With regard to diet, I would suggest that the following be tried for a case of "failing heart."

Breakfast.—Milk-tea or cocoa, dry toast and butter, a lightly boiled or poached egg.

Lunch.—Benger's food, some milk-chocolate—they like Peter's best.

Dinner.—Bovril or mutton broth, or some clear soup. A small piece of sole (not the ordinary hospital fish). No potato, a little green vegetable, chopped up fine, a small piece of stale bread or toast; of custard, sago or tapioca pudding, a small portion.

Tea.—Milk-tea or cocoa, dry toast and butter, a little jam (not plum).

Before settling for the night, a small cup of bovril or beef tea, or should the patient be thirsty, some lemon and hot water. Fluids should be taken with the meals in very limited quantities, and patient should be reminded that the less she can put up with, the better. This diet may be altered or enlarged to suit individual cases. The above diet was the one employed in almost all cases mentioned below.

Stimulants.—There is much difference of opinion. In my opinion, these failing heart cases do better with a small fixed quantity of well diluted spirits with their meals, and during the critical stage, four to six ounces of brandy helps very materially in pulling them round. Discourage, by every means in your power, the inclination to pick up the brandy bottle upon each and every attack of faintness or palpitation. For these attacks, the use of digitalis, with ten grains of each of the three bromides is most valuable.

There is yet another subject I will mention, and that is the question of—

Convalescent Homes.—All the cases of recent cardiac failure which are sent to convalescent homes, come back worse than they went. They do far better in their own homes, however poor they may be, though they may lose the enjoyment of a change of surroundings. I have no doubt that the routine life of "Parkwood," Swanley, and such places, is too much for any recently compensated heart. They are essentially a type of vessel about whom the barometer is continually rising and falling, and unless they steer their own course from day to day, the craft which has been through more than one typhoon before, will be very soon again upon its beam ends. If one morning the cardiac patient wishes to be late for breakfast, you will be wise if you allow him, and wiser still if you send it up to him, instead of allowing it to get cold. It is an interesting fact that Miss Henry's home at Worthing, where as you know, patients receive *individual* care and the kindest attention, is the only one from which you will see your patients return in better health than when they left your wards. I speak, of course, of cardiac cases. (Nos. 4, 21, 24, 12.)

Railway Journeys (*Nos. 18 and 23*).—I have just made a heading of "railway journeys," to remind you that many of your patients will wish to rush away to the

seaside or Riviera as soon as they feel better whether they are ready for the journey or no. Two of these cases I have made notes of, died as the result of shock from a railway journey which should never have been attempted. Be, therefore, exceedingly cautious when advising the relatives as to the ultimate benefit to be derived from a change of life and surroundings; for not a few patients such a journey may be the last.

(*c*) "*Wrecks.*"—Some of you may be inclined to remark upon the uselessness of treating incurable cases. There is no time to continue the subject, yet there *is* much that you can do to ensure that the lives of these patients, who are tied to their wheeled chairs or couch for the remainder of their days, are passed at any rate in tolerable comfort, simply by relieving those symptoms which I have detailed above. I can tell you of at least one lady, who to my knowledge has had two attacks of cardiac angina, with aortic and mitral disease. That was five years ago, and she has during that time enjoyed a useful and happy country life.

In conclusion, I wish to record my thanks to the late ward clerks to Sir Cooper Perry during my six months for their excellent notes, and to Mr. Reinhold and Mr. Louisson, the polished language of whose reports, while they were in Clinical, I have consulted.

For Appendix of Cases, see page 532.

Reviews.

The price of books submitted for review should in every case be stated.

An Atlas of Human Anatomy. By Carl Toldt, M.D. Translated by M. Eden Paul, M.D. Section VI.: Neurology and the Organs of the Senses. Pp, 240. (Messrs. Rebman, Ltd.) Price 16s. 6d. net.

This is the concluding volume of a large anatomical work, of which the previous parts have already been noticed in our pages, and with its issue the author is to be congratulated on having placed a well-known German work within reach of many English anatomists: for, though the price of three guineas is beyond the pocket of most students, its purchase will well repay those who can afford it.

The pictures in this section are of unequal merit; some are excellent, especially those showing the paths of various nerve impulses in the brain, and the commisural fibres extending between various nuclei, an excursion by the anatomist into the regions of physiology. The book has already reached a third edition in Germany, and consequently some of the plates must be rather worn, judging from a few of the reproductions in this volume; one on page 869 is very indistinct, the dotted lines indicating the names of various parts being hardly visible. Most of the figures are elaborate pictures of actual dissections, and we should like to see more diagrams—the more diagrammatic the pictures the better they are. There are few that the student will hang over his bedroom mantelpiece. There is an excellent series of sections of the medulla, and the development of the nervous system is very well illustrated. The brachial plexus is poorly shown, there being no diagrams but only a number of dissections, in which the parts are not well displayed, and the muscles not sufficiently separated. The anatomy of the eye is very well shown by numerous pictures, of which we espeeially like the view of the orbit from above and the various sections of the eyeball. The internal ear is well done, and a plate showing the lines of cleavage of the skin all over the body is quite new to us: "A subject which has important practical bearings on both surgery and dermatology." Each section has been indexed separately but no index to the whole work is given.

Medical Electricity. By H. Lewis Jones, M.A., M.D., Fourth Edition. Pp. xvi. and 536. (Messrs. H. K. Lewis.) Price 12s. 6d. nett.

This new edition of a well-known and popular handbook has been thoroughly revised and brought up to date by the addition of much new matter, thereby increasing the usefulness of the best *test-book* on the subject. What is the definition of a *hand-book* compared to a *text-book?* It opens with several chapters on the elements of electricity and the ordinary laboratory instruments, after which the author describes all the varieties of electrical appliances used in medicine. The practical side of the subject is kept well in view throughout, and many useful hints are given, both for the use and care of the instruments. Full directions are given for the management of batteries, and the ingenious will be glad to know that a tandem bicycle can be utilised to drive a dynamo.

A long chapter is devoted to the utilisation of current from the mains for medical and surgical purposes, and an appendix contains details of the nature of the current supplied for electric light in various towns.

The second half of the book is devoted to therapeutics, each pathological condition in which electrical treatment has been tried, and it includes most known diseases, is discussed, with details of the indications and prospects of that treatment.

The chapters on X-rays and radium have been considerably enlarged, and many cases are described from amongst those treated by the author at St. Bartholomew's Hospital, where apparently this department is very well provided. A series of interesting experiments is described, in which observers lying with their heads between the poles of a very powerful electromagnet, weighing 5,000 pounds, were absolutely unaffected, and in fact were unable to record when the current was switched on.

It would have enhanced the value of this standard work if more details as to cost and expense had appeared in its pages.

Bacteriology and the Public Health. By George Newman, M.D., F.R.S.E., D.P.H. Medical Officer of Health of the Metropolitan Borough of Finsbury. Third Edition. 1904. (London: John Murray.) Medium 8vo, pp. 497, with 31 plates and 48 figures in the text. Price 21s. nett.

Ostensibly the third edition of that volume of the Progressive Science Series dealing with "Bacteria," the volume under notice is to all intents and purposes a new book, for the scope and subject-matter, and even the size, binding, and price have been so altered and added to that it now bears very little family likeness to its predecessors.

As it now stands, "Bacteriology and the Public Health" is not merely a quasi scientific account of our present knowledge of bacteria, presenting the subject in a form calculated to enhance its popularity and secure for it a still wider circle of readers amongst the educated laity, but dealing as it does with the relations of bacteria, generally and particularly, to problems of hygiene and of preventive medicine with a breadth of grasp often strongly contrasted with minute accuracy of detail, it should become a favorite with the senior medical student and almost a necessity to the up-to-date medical practitioner.

In arrangement, the book is simple and clear. After preliminary discussion of the morphology and biology of the fission fungi and their response to alterations in environment, the author treats in turn of the relationship of bacteria to water and water supplies, the general principles underlying the bacteriological examination of air—incidentally commenting on the paucity of our knowledge in this connection—the chemistry of fermentation and the bacteriology of soil. Following these sections an interesting account is given of the economic application of bacteriology to agriculture and also to the disposal of sewage by means of bacteria beds. The bacteriology of milk and milk products as it affects both the hygienist and the dairy farmer is, as might be expected from one of the authors of the recent elaborate monograph on this subject, very ably dealt with. The contamination of food, such as shell-fish, ice-cream, and potted meats by bacteria and their products is also discussed, and many outbreaks of disease which have been traced to such sources described.

The remainder of the volume is chiefly concerned with bacteria in their pathological associations—tuberculosis being instanced as the type of bacterial disease; pathogenic protozoa chiefly in their relation to tropical diseases; and questions of immunity and the preparation of antitoxins.

Lack of space prevents us dealing even with this portion as fully as we would wish. Suffice it to say the author gives an excellent account of many bacterial diseases and indicates clearly the various methods devised by the bacteriologist for their treatment.

The volume concludes with an appendix running to some thirty-five pages on bacteriological methods, chiefly as applied to the examination of water supplies, which strikes us as being decidedly helpful, though somewhat sketchy. In this connection we should like to see Figs. 43, 44 & 45, representing obsolete pieces of apparatus deleted entirely. The plates, especially the coloured ones of colonies of acid-fast bacilli, are excellent, the type and paper good, and the volume, as a whole, well worthy of the place it will undoubtedly take in every medical library.

Notices.

Formawn.

Samples of Formawn tablets, as prepared by the London Chemical Works, for use in cases of nasal catarrh, have been carefully examined.

Formawn itself being liquid, the tablets are prepared by impregnating inert material with the liquid. Hot water causes Formawn to break up into menthol and formaldehyde. A very small amount of hydrochloric acid is also formed, but this is absorbed by the water. The irritating effect of the formaldehyde is to a very great extent masked by the fragrant odour of the menthol.

An excellent apparatus is supplied for generating and inhaling the formaldehyde—menthol vapour. Wadding, impregnated with Formawn, is also prepared by the London Chemical Works, 26, Southwark Bridge Road. This form has the advantages of being more portable and somewhat easier to use; the warmth of the nostrils being sufficient to effect the liberation of formaldehyde and menthol.

Formawn is said to have a very beneficial effect in catarrhal affections, and, as we have said, the irritation to the mucous membrane caused by inhalation of pure formaldehyde vapour is obviated. It has yet another advantage over most formaldehyde preparations, in that the aldehyde seems to have little or no tendency to polymerise, and is given off comparatively slowly.

Specialities.

Cadbury's Christmas Chocolates.

According to their wont at this season, the famous firm of Messrs. Cadbury Bros., have sent us a varied selection of their manufactures, comprising cocoa, chocolates, biscuits, and assorted creams in fancy boxes. As to the quality of Messrs. Cadbury's goods, we can only repeat the praise expressed regarding them on previous occasions in these colums. Suffice it to say, that they continue to be unsurpassed, and it is gratifying to perceive that in this branch of elegant production, we have no need to employ the foreigner. This is so, not only as regards the goods themselves, but applies equally to the charming manner in which they are presented to the consumer. The designs of the boxes and packages before us are artistic in a very high degree, and altogether charming.

APPENDIX OF CASES

	Age.	Occupation.	Lesion.	Cause	Symptoms first noticed.
1. E. L., female	—	—	Tachycardia ...	—	—
2. C. C., male ...	24	Clerk	Irritable heart ...	Over-exertion	—
3. C. S., male ...	38	Grocer	Fatty heart	Over-indulgence	—
4. M. M., female	40	Dressmaker. Had come down in the world.	Mitral stenosis ...	Rheumatic fever 21 years ago	Three years ago first noticed breathlessness, which has got worse since influenza 2 years ago
5. F. H., male ...	23	Driver, Horse Artillery	Soldier's heart ...	Rheumatic fever in 1900 ...	July, 1903. Discharged as unfit
6. C. G., male ...	51	Chemical factory. Not particularly hard work.	Double aortic disease	Syphilis 30 years ago	One year ago ... ...
7. J. C., male ...	34	Farm Labourer. 9 years previously in S. Africa	Double mitral disease	Scarlatina when a boy. No history of rheumatism. Influenza severely. Alcholic	Three years ago, dysyncea. Hæmoptysis
8. A. C., male ...	11	Schoolboy ...	Double mitral disease	Rheumatic fever, May to October, 1900; May, 1901; July, August, 1901	Since first attack of rheumatism
9. F. K., male ...	13	Schoolboy ...	Double mitral hypertrophied heart	?	Breathlessness since an illness (?) five years age
10. A. W., female	34	Housework ...	Double mitral disease	Rheumatic fever 3 years ago	Seven weeks before admission
11. A. G., male ...	7	Schoolboy ...	Mitral regurgitation. Diastolic bruit appeared on July 7th, also—	Scarlatina in June, 1904. No bruits heard in Brook Hospital. Discharge, June 25th. ? Scarlatinal endocarditis. ? Rheumatic. Formic acid in urine increased	One day before admission. Swollen joints; hæmaturia
12. S. S., female	51	Housework ...	Double aortic and mitral	? Cause. Sudden failure due to bronchitis	Palpitation after pneumonia 6 years ago. In 1901, admitted under Dr. Fawcett for double aortic and mitral incompetence. Quite well since discharge until 2 months ago when she had bronchitis
13. H. B., male ...	28	Clerk	Double aortic and mitral	Indefinite history of illness 9 years ago. Short of breath ever since	Nine years ago ... ...
14. J. P., male ...	15	Schoolboy ...	Double aortic and mitral	Rheumatic fever twice. First attack 1901	Since first attack in 1901 ...
15. G. L., male ...	38	Crane-driver ...	Aortic regurgitation. Compensating. Periostitis of right humerus	Has had rheumatism but no cardiac symptoms. ? Specific aortitis	Pain in right arm for six weeks before admission
16. E. H., female	34	Factory hand ...	Double aortic and mitral	First attack rheumatism in 1882. Third attack in 1887, with pericarditis	Liable to cardiac distress since 1887, from time to time
17. W. D., male...	38	Stevedore ...	Double mitral trouble	First attack rheumatism, 1880 (Dr. Moxon); also 1891 and 1893	First failed in 1894. Hæmoptysis. Mitral stenosis diagnosed. Since then has had no trouble until present time. Not so well for past 5 weeks. Acute bronchitis recently

APPENDIX OF CASES.

Treatment.	Admitted.	Termination.	Complication.	Later history.
Rest	Clinical No. 31, April 27, 1904	Discharged, May ...	—	November, 1904. Still liable to attacks, stronger in herself
Football and smoking stopped. Dieted ...	Front Surgery & Out-patients, February, 1904	Improvement, after two months	Occasional breathlessness	None ... .
Resistance exercises	Out-patient from February to September, 1904	Great improvement up to September, 1904	Breathlessness. Pain in the chest at first	Death from Pneumonia, October, 1904
Strophanthus suited her	Esther No. 7, March 14, 1904	Discharged, May 24, 1904, to convalescent home. Did her no good. Rather worse	Indigestion, nervousness, palpitation	Clinical. Re-admitted August, 1904; re-discharge, October, 1904; in statu quo, November 17, 1904
Digitalis. Rest. Strychnine. Hydrocyanic acid for sickness	Stephen No. 3, April 27, 1904	✠ July 23, 1904 ...	Vomiting for four days	P.M.—Heart weighed 40 ozs., hypertrophy, dilatation
Strychnine. Digitalis—Small doses. Morphia (no use). Hyoscine valuable	Stephen No. 6, May 21, 1904	✠ June 11, 1904 ...	Delirium ...	P.M.—Aortic atheroma, dilatation
Digitalis. Rest	Stephen No. 13, May, 24, 1904	Discharged June 16, convalescent home	None	None obtained, no reply
Digitalis. Rest	Stephen No. 10 May 25, 1904	✠ June 12, 1904 ...	Sudden vomiting. Fatal	P.M.—Adherent pericardium, mitral stenosis, acute endocarditis
Digitalis. Rest. Dieting	Stephen No. 9, June 17, 1904	Discharged much better, July 14, 1094	Indigestion ...	No reply ... ...
Digitalis. Rest. Light poultices to chest. Nitro-glycerine. Salicylates. Blister to præcordia	Esther No. 6, June 23, 1904	✠ July 22, 1904 ...	Pericarditis, cardiac angina, delirium	P.M.—Acute endocarditis, pericarditis
Rest. Milk diet. Allowed to walk on August 2nd	Stephen No. 19, June 29, 1904	Discharged, August 14, 1904	—	None ... ...
Rest. Digitalis. Caffeine, jalap, then arsenic and iron	Esther No. 8, July 14, 1904	August 12, 1904, convalescent home, Worthing, came back much better	Œdema ...	None ... ...
Strophanthus useless. Digitalis little effect. Strychnine. Rest. Brandy. Chloralamide. Nepenthe	Stephen No. 13, July 18, 1904	Went out at his own request September 28, 1904. Home worries	Insomnia, palpitation, dyspnœa, œdema	Readmitted October, 1904, much worse; November 18th, practically no change, temporary improvement
Salicylates. Digitalis. Rest. Hot flannels to chest	Stephen No. 18, July 20, 1904	✠ August 10, 1904 ...	Pericarditis, pain, anorexia, vomiting	P.M.—Recent endocarditis, pericarditis
Mercury. Iodide. Scott's ointment. Massage for wasting	Stephen No. 20, July 25, 1904	Discharged, September 6, 1904. Bruits less marked. No pain in arm	None	November 18th. Has been at work six weeks, no failure, feels very well, still taking iodide
Digitalis. Rest. Strychnine. Morphia...	Esther No. 16, September 8, 1904	✠ September 12, 1904	Œdema, dyspnœa, nightmare, fatal	P.M.—Old pericarditis, button-hole—mitral, short, thick, aortics
Venesection ʒxxii. Rest. Digitalis. Strychnine. Morphia. Brandy. Dieting. Codeine	Stephen No. 16, August 14, 1904	Discharged at his own request, feeling quite well, September 21, 1904	Bronchitis, flatulence, insomnia	November 18th. Has been at work for six weeks, no œdema, slight irregularity, feels fit

APPENDIX OF CASES—continued.

		Age.	Occupation.	Lesion.	Cause.	Symptoms first noticed.
19.	R. C., male ...	32	Oil refiner ...	Double mitral trouble	No rheumatic history. Best of health until 6 months ago when he had pleurisy and pneumonia. Has been very weak ever since	Nine weeks ago went down to Folkestone; did not improve. Seven weeks ago, œdema appeared
20.	G. S., male ...	—	Was in the Army. Invalided for heart trouble. 3 years in India. Malaria. Now Newsp'r Packer	Double aortic disease Mitral regurgitation	Rheumatic fever when 12 years. Three attacks in India Acute rheumatism on admission	Breathlessness for the past year
20.	J. M., male ...	28	Carman ...	Double mitral disease Hypertrophied heart	?	—
21.	F. N., male ...	19	Compositor ...	Aortic regurgitation. Double mitral	Chorea in 1894. Sub-acute rheumatism in May, 1891	Failure in May, 1901. Mitral obstruction diagnosed. Bronchitis in December, 1903. Readmitted Jan., 1904; went out in six weeks contrary to advice
22.	E. K., male ...	41	Wine Merchant, City	Fatty heart. Cardiac angina	Over-indulgence	Breathlessness for 6 months. Sudden attack of pain with collapse while at work in the City. Vomit examined. Negative.
23.	F. R., male ...	36	Labourer ...	Aortic and mitral ...	Rheumatism 15 years ago ...	Two years ago ... ...
24.	W. B., male ...	42	Old Army man. Joined at 20 yrs. 3 yrs. in India, 7 years in all. Malaria. Ostler	Myocarditis. No bruits	Alcohol	June 15. Three months ago, breathlessness. Six weeks ago, gave up work. 10 days ago, went to Margate; next day not so well. Sept. 9, œdema started; bed. Sept. 12, return
25.	W. Bl., male...	42	Labourer ...	Myocarditis. Mitral regurgitation	Alcohol	Scarcely 3 months ... ...
26.	J. A., male ...	40	Labourer ...	Aortic and mitral ...	Rheumatism	Some years ago ... ...
27.	W. S., male ...	28	Clerk	Mitral disease. Regurgitation	Rheumatism when a boy ...	Three years ago ... ...
28.	G. M., male ...	17	—	Mitral stenosis ...	Rheumatism	Five years ago. Never well since then. In and out of hospital
29.	H. S., male ...	40	Farm labourer	Aortic regurgitation. Moderate	Atheroma. Syphilis	Three years breathlessness ...
30.	E. C., female	50	—	Aortic regurgitation. Mitral regurgitation	Rheumatism	?
31.	L. A., female	20	Housemaid ...	Mitral obstruction ...	? Rheumatism some years ago	Three weeks discomfort. Sudden failure with acute bronchitis

APPENDIX OF CASES—continued.

Treatment.	Admitted.	Termination.	Complication.	Later history.
Digitalis. Brandy. Strychnine. Nepenthe.	Stephen No. 19, August 17, 1904	✠ Did not get over the effect of railway journey from Belvedere	Anasarca, vomited just before death	P.M.—Tricupid stenosis. Mitral 2½in., tricuspid 3¾in. Congestion of stomach; old and recent infarcts in spleen and kidneys.
Digitalis. Brandy. Strychnine. Salicylates. Dover's powder. Hot flannels and poultices. Caffeine. Jalap. Dieting	Stephen No. 23, September 12, 1904	✠ Died at dinner time, October 5, 1904	Pericarditis, pneumonia, pleurisy, pleuritic effusion, œdema	P.M.—Acute pericarditis, endocarditis, effusion ℥xxv.
Digitalis. Rest. Caffeine. Codeine. Dieting. Jalap	Stephen No. 1, September 25, 1904	Went out too soon, October 19, 1904	Œdema, bronchitis, indigestion	November 17, 1904. Has not been to work; not so well; jaundiced slightly.
Strychnine. Digitalis. Venesection; much relief on two occasions. Brandy (at first). (Convallaria. Strophanthus. Cactus grand. of no use). Mercks digitoxin by the mouth started vomiting. Digitalin hypodermically useful. Morphia	(1) Stephen No. 4, April 5	To convalescent home, not so well on return but enjoyed it, July 15, 1904	—	P.M.—Hypertrophied and dilated heart; old endocarditis.
	(2) Stephen No. 10, August 11	✠ November 4, 1904	Insomnia, palpitation, vomiting	
Oxygen. Nitro-glycerine. Rest. Purges	Stephen No. 8, April 27, 1904	Discharge after a few days	—	November 16, 1904. Breathlessness at times. No further attack of angina.
Admitted February, 1904. Went to convalescent home, came back worse. Readmitted later Digitalis	Stephen No. 14, May 16, 1904	✠ May 20, 1904, sudden	—	P.M. — Infective endocarditis
Digitalis. Strychnine. Venesection ℥xv. Venesection ℥x. Gave relief for a short time only. Croton oil	John No. 15, September 15, 1903	✠ November 6, 1904	Dyspnœa, bronchitis, pleuritic effusion, anasarca, embolism of sup. mesent. Infarction of lung	P.M. — Valves healthy, pale and fibroid muscle, dilatation. Weight, ℥xxiii.
Digitalis. Strychnine. Venesection ℥xv. pulled him round for a time. Jalap. Chloral and bromide. Nepenthe	Stephen No. 7, February 28, 1904	✠ April 23, 1904 ...	Dyspnœa, anasarca, sleeplessness	P.M. — No endocarditis, dilated left side, myocardial degeneration
Digitalis. Strychnine and morphia ...	Stephen No. 19, May 21, 1904	✠ May 22, 1904, sudden	Dyspnœa ...	P.M. — Infective endocarditis
Digitalis. Rest	Stephen No. 21, April 25, 1904	Discharged. Compensation, June 10, 1904	—	Doing well four months later
Iron. Arsenic. Strychnine. Salicylates	Stephen No. 9, September 9, 1904	November 6, 1904 ...	Indigestion, nervousness, tachycardia	November 18. Living at home, no good for anything
Sodium nitrite. Caffeine. Opium ...	Stephen No. 22, September 12, 1904	Discharged much better October 2, 1904	Sleeplessness, headache	None
Digitalis. Strophanthus. Hunyadi water. Bromides. Carminatives	Esther No. 10, February 2, 1904	Discharged no better July 16, 1904	Flatulence, palpitation	Practically tied to a chair
Digitalis. Stramonium. Lobelia. Dover's powder. Brandy.	Esther No. 20, August 4, 1904	Discharged September 30, to Worthing convalescent home	Insomnia, incessant cough	Came back much better. November, doing well.

Sport.

Rugby Football.

RICHMOND v. GUY'S HOSPITAL.

Played at Richmond on Saturday, December 3rd. Guy's had their full team out in this game, but Richmond had two good men away. Soon after play started, Richmond attacked, but good collaring by Jones and McEvedy prevented a score. The Guy's forwards at this period of the game, and in fact all through, were holding the scrums well, but could not get the ball out. Time after time the Richmond backs had the ball clean from the scrum, but could not score. After a good run, Hancock went into touch, and throwing the ball far out, Palmer took it rather luckily and scored. After the kick-out, Guy's three-quarters were kept continually defending, but could not prevent Richmond scoring another try, from which they kicked a goal. At half-time Richmond were leading by a goal and try to nil.

During the second half, Guy's had more of the play, and on several occasions were near scoring; towards the end the forwards got the ball out a little, and Digby, McEvedy and Stringer all made good runs. Early in this spell Richmond scored two tries, one by Hancock and the other by Godfrey, the latter should certainly have been collared, but managed to struggle through. The last quarter of an hour saw Guy's attacking, but they could not quite manage to score, Richmond winning by two goals and two tries (16 points) to nil.

REMARKS.—Husbands at full-back was good at times, and showed plenty of pluck in stopping rushes, his right foot kicking was good, but his left foot kicking was very feeble. The three-quarters all collared splendidly, and had few chances of attacking. The halves were under a disadvantage, as they did not get the ball out, but time after time Hancock was allowed to run round the blind side, even with a forward out of the scrum; this should have been prevented. The forwards held the scrums well and were good in several rushes, they must reach farther for the ball in the scrums. When the ball is out, they want to break up quicker and get across the ground to help the three-quarters, in defence especially.

Hockey Note.

GUY'S II. v. GREENWICH.

The above match was played at Kidbrooke on December 3rd, and resulted in a win for us by 6 goals to 5. We had a fast game on the whole, the ground being greatly improved. We ought to have won by more points than we did, but the shooting of the forwards was very poor and the defence behind being very weak. Team:—

GUY'S.—Mills (goal); Basker, Reinhold (backs); Rankine, Thomson, Mollison (halves); Dick G. Morris, Miller, Ponder, A. Palmer (forwards).

United Hospitals Hare and Hounds.

SHORT DISTANCE HANDICAP.

The short distance handicap of the above club was held on December 14th, having been postponed from November 26th, on account of the weather. Unfortunately the new date was not nearly so suitable to Hospital men as the original one; however, thirteen men faced the starter, and all finished. The race was run in the rain, over the 5½ miles course, at Blackheath, the going being somewhat heavy. All the men started level, it being a sealed handicap. Candler was easily the first man home, though had Birt (R. Dental) and Linnell (London), been running, there should have been a good struggle between the three for this honour.

The result was:—

Actual Position.	Name.	Hospital.	Actual Time.	Hcp.	Hcp. Time.	Position in Hcp.
1.	A. L. Candler...	Bart.'s	34 28⅖	scr.	34 28⅖	4
2.	H. W. May ...	Bart.'s	35 56	2 5	33 51	2
3.	W. H. Watson..	Guy's	36 7	2 30	33 37	1
4.	T. E. A. Carr ...	Guy's	36 11	1 10	35 1	7
5.	A. R. Snowdon.	Bart.'s	36 46	2 0	34 46	6
6.	V. Townrow ...	Guy's	37 8	2 25	34 43	5
7.	J. Beckton ...	Bart.'s	38 23	3 20	35 3	8
8.	E. S. Molyneaux	London	40 9	5 0	35 9	9
9.	K. H. Digby ...	Guy's	41 45	7 30	34 15	3
10.	W. F. V. Simpson	London	42 2	4 20	37 42	12
11.	W. Johnson ...	Guy's	44 47	8 0	36 47	10
12.	H. S. Burnell...	London	45 1	8 0	37 1	11
13.	E. F. Rainey...	London	45 39	6 0	39 39	13

The handicap medals were thus won by Watson, May and Digby, the fast time medal falling to Candler.

Appointments.

Naval and Military.

Surgeon H. G. F. MAJOR, R.N., and Surgeon G. L. BUCKERIDGE, R.N., are appointed to the *Bulwark*.

Surgeon-Lieutenant-Colonel F. W. HUMPHREYS, 15th Middlesex (Customs and Docks) Volunteer Rifles, is granted the honorary rank of Surgeon-Colonel.

Births.

BETT.—On December 20th, at Ingleton, Greenhill, Weymouth, the wife of Fleet-Surgeon William Bett, R.N., of a daughter.

GRIFFIN.—On December 8th, at Melville Hall, Ryde, Isle of Wight, the wife of Wilfred E. Griffin, L.D.S., of a daughter.

LE FEUVRE.—On November 9th, at Bulawayo, the wife of W. P. Le Feuvre, M.R.C.S. Eng., L.R.C.P., of a daughter.

PENNINGTON.—On December 8th, at Carter House, Argyle Road, West Ealing, the wife of Dr. S. B. Pennington of a daughter.

RICHARDS.—On December 4th, at Croydon, the wife of J. Stewart Richards, M.D., B.S., of a daughter.

ED.—R. E.

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